ARCHIVES OF SURGERY.

JANUARY, 1893.

PEMPHIGUS DURING SECONDARY SYPHILIS (*two cases*).

An eruption deserving of the name of acute general pemphigus, during the course of syphilis, is in my experience one of the very rarest events. The two cases which I am about to record are by far the best examples of it which I have ever seen. They were both under observation during the same year. In several features they are close parallels to each other. In both, the use of specifics in the early stages of the disease had been neglected. In both, the patients were at one period so ill that a fatal issue was feared. In both, iodides appeared to do definite injury; indeed it may almost be said that in both there is a possible fallacy as to whether the pemphigus was really syphilitic, in that it may possibly have been caused by the iodides. In both cases arsenic appeared to exert a specific power over the pemphigus, just as it does in the non-syphilitic form, and both were finally cured by it. We have here again, however, the fallacy that it may possibly have been the leaving off of the iodides, as much as the use of the arsenic, which was beneficial. In both cases mercury was well borne, but did not cure the pemphigus until arsenic was given along with it. In both cases it seemed that the arsenic did much more good when it was given alone

concurrently with mercury, but not in combination with it. Thus it will be seen that in addition to their interest as examples of a very rare form of syphilitic eruption, the cases convey most important lessons in therapeutics.

A bullous eruption which ends in ulceration and in the production of the limpet-shell crusts of rupia, is of course not uncommon in syphilis. It occurs usually rather late amongst the secondary symptoms, and it may in some instances, from the size and persistence of the bullæ, seem to approach a condition of pemphigus. It is, however, a totally different eruption from that now under consideration. Its difference is shown in its tendency to produce the conical crusts, and in its far less acute and extensive outbreak. The character of the scar left is also quite dissimilar. Rupia leaves indelible, and rather deep, shilling-like scars, whilst in the present cases the scars were very superficial and ill-marked, being, in fact, pigmented stains rather than true scars.

In reference to the possibility that iodide of potassium was the cause of the bullous part of the eruption, I must explain that it was not known exactly what had been given in the early part of the disease in either case. I am not in a position to assert in either that iodides had been given before this feature in the eruption was assumed, but in both it is possible. During the later stages of the disease it is beyond doubt that, on several occasions, and in both cases, the addition of iodides to the prescription greatly aggravated the eruption. In case II., in fact, on at least two occasions, bullæ were produced, by the addition of iodide, after they had ceased to appear. We did not at first suspect the iodide, and it will easily be seen that cases of such severity, attended with such great cachexia, were exactly those to tempt us to disuse mercury and to substitute the iodide. It was not indeed till near the conclusion of both cases, and when I compared the notes of the two together, that the suspicion became strong that the iodide might have been actively injurious.

I have displayed both cases in Schedules constructed on "the space-for-time method," believing that it will best enable the reader to grasp the details.

CASE I. — *An indurated chancre. An eruption resembling varicella in third month. Eruption bullous on limbs and erythematous on trunk. Mercurial treatment. Imperfect cure. Persistence of eruption, pemphigoid and rupial, in spite of ptyalism. Apparent increase of eruption from iodide. Severe cachexia. Recovery under Arsenic and Mercury after a year's illness.*

DATE.	DETAILS.
1891 August *Second month.*	An indurated chancre. No special treatment. A copious eruption appeared, which on the limbs "exactly resembled chicken-pox." No mercurial treatment as yet.
September *Third month.*	(First seen by me.) His limbs were covered with bullæ. (Portrait taken.) On the trunk the eruption erythematous only, copious on the back. A very hard chancre and bullet glands in groin still present. Mercury commenced. Sores in tonsils and under tongue.
October *Fourth month.*	Mercurial treatment (but not under my own observation). A grain and a half of grey powder six times a day.
November *Fifth month.*	Mercurial treatment. The same pill. Eruption still persisting. Not under my observation. Iodides used at times.
December *Sixth month.*	Mercurial treatment. Eruption still persisting. I heard of him by letter, but did not see him. "In a pitiable condition." Mercury left off, and iodide of potassium in ten-grain doses substituted.
January *Seventh month.*	The eruption did not improve under the iodide, and the mercurial pills were, after a fortnight's intermission, resumed four times a day. Subsequently the iodide with bark given together with mercury.
February *Eighth month.*	The iodide made him sick, and the eruption was worse. It was left off. Under mercury alone he much improved, and the eruption almost disappeared.
March *Ninth month.*	Mercurial treatment and slight ptyalism. Much better, but unable to sleep and troubled with night sweats.
April *Tenth month.*	Seen by me for the second time on 7th. Emaciated and weak, covered by a pemphigoid eruption, affecting limbs chiefly, but trunk also. I suggested iodide. It appeared to bring out more bullæ, and he became so weak that he was confined to bed.
May *Eleventh month.*	Very ill. Still taking both iodide and mercury, but in combination with arsenic. No fresh bullæ; Ptyalism. It is certain that the arsenic has prevented the development of new bullæ.
June *Twelfth month.*	Improving, but only very slowly, and the eruption still persisting. Emaciated. Fresh bullæ occasionally.
July *Thirteenth month.*	Mercury and arsenic given separately, but at same time iodide left off. Immediate improvement.
August *Fourteenth month.*	On the 19th he had not for a fortnight had a single fresh pemphigus bleb. Much better in all respects.
September *Fifteenth month.*	Improving in all respects. Gaining flesh. Surface of trunk covered with superficial scars and dark stains.
October *Sixteenth month.*	Has returned to his work after a year's severe illness, and is strong and well. Free from eruption. (Subsequently some tendency to return of pemphigus.)

Case I. (see preceding Schedule).—When I first saw this case, the arms and legs were covered with pemphigus of such a marked character that I at once had a portrait executed for the College of Surgeons Collection. It may now be seen there. Up to this time the man had not had any skilled treatment. He still had the remains of his chancre, and some very hard glands in his groins.

Mr. George Stevenson, who brought the man to me, had diagnosed syphilis, and had just begun mercurial treatment, but until within a few days of our consultation the man had had no good advice, and had taken no mercury. A remarkable feature was that the eruption was bullous on the extremities but only erythematous on the trunk. It was abundant on the back, but less so on the abdomen. The bullæ presented every gradation in size from varicella-like vesicles to that of half a billiard ball. There was a good deal of erythematous swelling of the skin beneath the bullæ. Mr. Stevenson told me that the eruption had in its first stage looked exactly like chicken-pox. The evening temperatures had been 100. There were superficial sores in the tonsils and under the tongue.

We prescribed mercury. He took the Hydr. cm Cret. in doses of a grain and a half, with a little opium, six times a day for about two months, and then for a short time eight times a day. He was better, but not well. On December 30, as he was very weak and the eruption still persisted, mercury was laid aside, and iodide of potassium in ten-grain doses in sarsaparilla substituted.* This did not seem to agree. The eruption increased and mercury was again resorted to. During January, under mercury alone he improved. The iodide was again given for a fortnight in conjunction with mercury, and he seemed worse for it. Towards the end of January, under mercury alone he got almost well. Subsequently he became very weak, had night perspirations, and although his gums were spongy the eruption persisted. Iron and strychnia were now tried, and again the iodide was given. Again, however, he relapsed, and mercury had to be again resorted to.

* I am not sure that he had not taken some iodide with the mercury before this date.

This patient lived in the country, and he passed from under the observation of Mr. Stevenson as well as myself. I did not see him again for seven months. During the latter part of this time he had been skilfully watched by a practitioner in the country.* Our first consultation had been on Sept. 9, 1891, and the second was on April 7, 1892.

On this latter date he came to me in a wretched state. He had lost flesh and colour, and although slightly salivated was still covered from head to foot with eruption. His limbs were still much more severely affected than the body, but the trunk did not escape. The hands were wholly free, the vesication ending abruptly at the wrists. There were numerous superficial scars. Many of the sores had low crusts, but they did not approach the limpet-shell form. There were but few well-formed bullæ, not nearly so many as on the former occasion.

From April to August I saw him once in six weeks, and we persevered with a mixed treatment of mercury, arsenic, and occasionally iodides. He continued very weak, and the eruption still persisted. The bullæ were smaller and less persistent than they had formerly been, and more crusts were formed. He was still in a deplorable condition.

On July 13, guided by my concurrent experience of Case II., I made the change which effected the cure. It consisted in the use of mercury and arsenic in separate doses. He took a grain and a half of grey powder with a little opium, and four minims of Pearson's solution in a mixture at the same time, four times a day. He began to improve directly, and on August 19th I was able to record that no fresh bullæ had appeared for a fortnight. He was then slightly salivated. After that his progress, though slow, was steady. At the present date he is well and fairly strong, and after his fourteen months' severe illness has resumed his work as a butcher. He is covered with dark stains and superficial scars.

* I believe that during most of this time he took iodides more or less.

CASE II.—*Syphilis imperfectly treated during five months. Lichenoid eruption, which subsequently became vesicular. An attack of facial erysipelas nearly fatal. Albuminuria. Acute iritis. Specific treatment commenced in fifth month. Great emaciation and a well-marked pemphigus eruption. Definite benefit from Arsenic and Mercury. Iodides injurious.* (*Patient, a barber, aged* 56.)

DATE.	DETAILS.
September *Second month.*	The sore appeared (one month after contagion). He denied exposure, was believed, and no diagnosis was made.
October *Third month.*	The sore is said to have been phagedænic, and caustic was used. An eruption appeared.
November *Fourth month.*	Details of treatment not known. Very ill, with copious eruption.
December *Fifth month.*	Was made to take very hot baths. No diagnosis of syphilis.
January *Sixth month.*	A severe febrile illness. Temp. 104 repeatedly. Albumen in urine.
	On Jan. 10th the eruption was partly squamous and partly bullous. Bullæ quarter of inch in diameter, with no inflammation.
February *Seventh month.*	12. Was seen by my son, and syphilis first recognised. Liq. Hydr. in drachm doses given. He was covered with a lichenoid and papular eruption.
	24. Acute iritis in right eye. Skin absolutely covered by a mixed eruption, papular, bullous, and lichenoid.
March *Eighth month.*	I ordered increase of mercury, with seven grains of iodide. On the 9th I ordered Liq. Hydr. ʒj, with cinchona and arsenic.
	On the 14th I visited him at his own house, and found him exceedingly ill and covered with pemphigus. Ordered to omit iodides and take arsenic and mercury separately.
April *Ninth month.*	21. His eruption was wholly gone.
	26. He came to my house covered with stains and scars, but wholly free from eruption.
May *Tenth month.*	Is taking four-minim doses of Fowler's solution with mercury in pill. Is quite free from eruption.

After the last note he remained quite free from eruption. He had some nervous symptoms which induced us to discontinue the arsenic, and he took mercury only. He is now quite well.

The subject of Case I. was a healthy man of about 35. That of Case II., a barber by occupation, was older, being nearly 56. Although not robust, he had shown no special signs of failing health until the syphilis. I shall in this instance content myself with the schedule form of narrative, and will merely remark that the pemphigus character of eruption was most definitely marked. When I saw the patient on the 14th of March he was covered by large bullæ, which presented no feature of difference from those seen in the worst cases of the non-specific form.

Idiosyncrasy on the part of the patient is the only explanation which can be offered of these erratic forms of syphilitic eruption. It will be seen that in both these patients the peculiarity involved not only susceptibility to special influence from the syphilitic virus but also from the iodides. About the latter fact there could be no doubt, although I do not really believe that in either the iodide actually caused the eruption to assume a bullous type, yet in both it most certainly aggravated it.

Although pemphigus is so rare as a secondary eruption in acquired syphilis, yet we may remember that it occurs under exceedingly peculiar conditions in infants inheriting taint. In them it is almost always the precursor of speedy death, and is seen, contrary to rule, within a week of birth, or may even be present from the first day. It is also usually limited to the hands and feet, parts which were exempt in the cases I have narrated.

POST-MARITAL AMBLYOPIA (BURNS' AMAUROSIS).

"Mr. Burns" was a young lawyer, who was in May, 1874, apparently in good health, and only a few weeks married. He was brought to me so nearly blind that he could but just see letters of 200 at six feet. On use of the ophthalmoscope, nothing was discovered. He had no other nervous symptoms, excepting a little headache. He was a man of temperate habits and sound health. The failure of sight had developed rapidly in the course of about ten days. I insisted on abstention from sexual intercourse, and gave tonics with mercury. In a few months he was quite well. He has ever since enjoyed good health and perfect sight, and intercourse in moderation has now no injurious influence on him. I have seen him quite recently, after an interval of sixteen years from his attack of amblyopia.

In the Lecture* from which I abstract the above case, I have narrated another, the particulars of which I had from its subject long after his illness. A gentleman in strong health, and the father of a large family, told me that in early youth he had been brought by his father to a London oculist, because he was almost blind. He assured me that the only cause of his condition was that he had been allowed, as being but a boy, to sleep in the same room with a servant girl, who used to persuade him to have intercourse with her. On his being taken away from the company of this girl, his sight returned, and it never afterwards failed in the least.

A third example of this form of amblyopia, and also of complete and permanent recovery both of sight and health, has quite recently presented itself.

* Mr. Burns' case is recorded in a lecture delivered by me in 1876 at the Moorfields Hospital, and published in Vol. IX. of the Reports, page 10. I am glad now, after an interval of sixteen years, to be able to complete it.

A married man of 32, in robust health, gave me the following history of what had happened to him in early life. At the age of 18 he fell suddenly into dissolute habits, and indulged to great excess in sexual intercourse. He smoked also. The failure of his sight developed rapidly from a "dull haze before me" to complete blindness. "I was quite blind," he said, "for three weeks." "Could you have seen your hand held before you?" "No, nothing." Several surgeons were consulted, and ultimately Mr. George Critchett, who used the ophthalmoscope. There was question whether it was due to syphilis, but Mr. Critchett said that it was "solely of nervous origin, and due to exhaustion from excess." He had, in reality, never had syphilis. After about three weeks' blindness the sight returned, and it has ever since been excellent. Mr. —— has, during the fourteen years which have since elapsed, led a very energetic life, engaging in exploring and wild sports, and he has never experienced the slightest failure of any nerve function. He has now been married for six years, and reports that he is in all respects "strong." He has the appearance of being so. I examined his eyes with the ophthalmoscope, and found the discs florid and in every way normal.

These three cases, so remarkably alike in their features, might lead us to believe that post-marital amblyopia is, like that due to smoking, usually recovered from, and that no relapse occurs although sexual indulgence is resumed. Recovery and freedom from relapse are very definite features in the best-marked examples of tobacco amblyopia. The failure of function which I am now describing, has, indeed, remarkable features of similarity with that due to tobacco. It differs from it chiefly in being much more rapid in its development, and in passing to a much higher degree of amblyopia. Tobacco cases usually require months to develop, and rarely proceed to any condition approaching blindness. They recover also much more slowly than do these post-marital cases. As regards recovery, it may be remarked that there are possibly in both series a few cases in which the disease advances to complete and permanent blindness. It

may be conjectured that this may happen in cases in which the cause is never suspected and never removed. The cases under notice are not, as a rule, attended by any failure of sexual power, nor are the tobacco cases attended by any distaste for smoking, or consciousness on the part of the patient that it is injuring him. It might be difficult, perhaps, in the case of tobacco amblyopia to produce any cases of permanent and complete blindness which should be beyond doubt as to correctness of diagnosis. I am sure, however, that I have seen a few which were probably such. That they are very exceptional to rule, all will admit. It is the same with the amblyopia now under discussion. Recovery is certainly the rule. Mr. Travers has recorded a case in which a robust farm lad became the favoured paramour of two girls, his fellow-servants. "Gutta serena," presumably permanent, was the result within a twelvemonth. I have myself seen one patient, a healthy young married man, whose sight began to fail a few weeks after marriage, and in whom the condition advanced to absolute and, I believe, permanent blindness. When I saw him he had white discs, but was wholly free from other symptoms of disease of the nervous system. Neither in Mr. Travers' case nor my own can the sequel of the case be given, and it is obvious that with this omission the diagnosis is open to doubt. Organic disease of the brain does not always disclose itself early.

The cases which I have narrated suffice, I think, to show that young men who have recently assumed habits of frequent sexual indulgence (whether in marriage or otherwise does not matter), are liable to have their sight fail rapidly, without other symptoms. The "blindness" resulting from this cause is usually only transitory, and the recovery is complete and without liability to relapse. Inasmuch as this form of amblyopia presents well-marked peculiarities, necessitates a peculiar treatment, and justifies a special prognosis, it will, I think, be convenient to recognise it under a definite name, and I venture to propose that it be called "After-marriage Amblyopia (the Burns type)." I would rigidly exclude from the group all cases in which the cause is doubtful.

Vere scire est per causas scire, and I should like to insist

that, although other cases in association with other not wholly dissimilar causes may perhaps be found, yet that it is desirable to keep the groups separate. I have above pointed out post-marital amaurosis has features of resemblance to tobacco amaurosis, and it may perhaps be the case that the failure of sight sometimes observed after parturition is similar in kind. I would, however, any rate for the present, keep these all in special groups. Rapidly produced and all but complete blindness, without visible changes, and with the possibility of rapid and complete recovery, are the main features of all.

The habit of masturbation and great excess in sexual indulgence under any circumstances, may each in turn, I feel sure, induce failure of sight, and derange the nutrition of the eyeball. The post-marital form of amaurosis is, however, quite distinct, and never, I believe, occurs excepting to those who have been newly placed under conditions tempting to excessive indulgence. Under the other circumstances the failure of sight is very gradual and usually permanent, and is attended by symptoms of general neurasthenia. In the Burns' type it is sudden, and stands alone.

BARTOS' DISEASE (ALIBERT'S PIAN RUBOÏDE).

I would venture to suggest that the case which is the subject of Plate XXXV. in the beautiful atlas of Alibert, and which he names Pian Ruboïde, should be known, temporarily at any rate, as Bartos' disease. Bartos was the name of the patient, and he has been fifty years in his grave. The case is a very peculiar one, and, with the exception of histological facts, it is complete. We have the patient's history, an excellent portrait, and a full narrative of the post-mortem. The facts were briefly these : A healthy married man, aged 30, a thresher, died of exhaustion after an illness which had lasted not more than a year, possibly not more than six months. The dates are a little uncertain. This illness had commenced by the formation of little raspberry-like growths on the lips, which had been followed by similar growths over the whole of his scalp, over the pubes, and some other parts. He had continual coryza, and became emaciated and very weak. The portrait shows the back of his head, covered with florid papillary growths ; the patches are as large as the palm of the hand, and their surface much resembles cauliflower buds. So far as the narrative goes there was no gland disease. At the post-mortem some small swellings which contained pus were found about the larynx.

What was Bartos' malady? Certainly it ought not to be hastily assigned to the group of granuloma fungoides. For if it were so, it would certainly be put with others essentially different from it. Clearly the disease was an infective one, and the original sore on the lip was very probably acquired by contagion. In some features it much resembles a case recently published by Dr. Prince Morrow, and named by him Tuberculosis Papillomatosa Cutis. Or, was the case one allied

to pemphigus vegetans? Is it even possible that it had anything to do with chronic farcy? It is not possible to answer any of these questions definitely, and the wisest course seems, to me, to let the case for the present stand by itself, giving to it a definite name by which dermatologists and others interested in the subject may remember it, and keeping clearly in memory the portrait by which Alibert has illustrated it. To continue the name Pian Ruboïde would be, I fear, to perpetuate the risk of error, by suggesting that the case has real relationships, which it probably has not, with other maladies which have been named pian. Better, I think, to know the disease by the wholly colourless name of the man who was its subject.

In illustration of the superior propriety of employing the name of the patient, I may mention that Alibert's portrait has been copied in another atlas with a wholly different pathological name attached to it. Not improbably it has been referred to by other authors, and as often re-christened. If we keep to the patient's name, we shall at any rate know what case we mean and what its clinical features were. So far as the affection of the skin of the scalp goes, a few more or less similar cases might be cited. I possess a portrait of at least one such. I do not, however, know of any in which the whole history of the case was parallel with that of Bartos, nor any in which a fatal cachexia resulted.* I shall be much gratified if any of my readers can direct my attention to any such.

* The portrait of "Sycosis Frambœsiformis," which is given in one of Hebra's plates, represents the back of the head of a man with a pustular and furunculoid eruption on the nape of his neck. The back of the hairy scalp shows a large patch covered with florid papillary outgrowths very similar to those in Alibert's portrait of Bartos' case. Unfortunately I have not found any history of this individual patient, and there is no reason to suspect that it was a case which ended fatally.

Under the name of "Elephantiasis affecting the scalp and other parts," Dr. Thomas Goodfellow, who was at the time a house physician of the Manchester Royal Infirmary, recorded in the *Illustrated Medical News* the case of a man named James S——, *æt.* 51, in whom the conditions as delineated appear to have much resembled those of Bartos'. It is also stated that the man was ill, and had sores on his face.

NOTES ON DIPHTHERIA.

It is not possible, if my views as to the nature of the disease are correct, to construct any accurate statistics as to the ratio of fatality from diphtheria. We are dealing with a name to which it is not practicable to give any precise limitary definition. No one can say where inflammatory sore throat ends and "diphtheria" begins. One observer might legitimately count all cases of sore throat occurring in a household in which there were any definite cases of the diphtheritic type as belonging to that category. He would probably be quite correct in doing so, but clearly his statistics of ratio of fatality would be much better than those of another observer who used the name only when definite and considerable formation of membranes took place. We can at the best produce fragmentary or, in some instances, little better than anecdotal statistics. In what I have previously written on this subject, I have dealt with it somewhat after this fashion, and I confess I am not without a hope that it is possible in this way to create impressions which shall be quite as truthful as those based on more extended numerical calculations.

It may perhaps be as well to state at once that I am concerned to uphold the following propositions:—

First, that the name "diphtheria" is applicable not to a specific fever, but to the consequences of a local inflammation which affects usually, but by no means invariably, the throat and air passages.

Second, that diphtheritic inflammations may be induced by cold-catching, and that when so induced they may become, as ordinary colds often do, contagious to other persons.

Third, that there is no difference in nature between croup and diphtheria, excepting that in the latter malady the inflammation has developed in high degree its contagious properties.

Fourth, that it is probable that a diphtheritic inflammation which has itself originated by contagion becomes, on that account, far more contagious than one which has been developed in connection with taking cold.

Fifth, that the spread of diphtheria in epidemics, in hospitals and in families, is to be wholly accounted for under the known laws of contagion, and that it is not probable that local conditions, such as defective drainage, &c., apart from exposure to cold and damp, take any material share in its production.

Sixth, that the laws of idiosyncrasy are very influential in reference to the severity of diphtheritic inflammation. Certainly some persons and some families are remarkably prone to suffer.

Lastly, as already implied, it is not possible to mention any one symptom or sequela which is characteristic of diphtheria. Thus the presence of membranes is certainly not invariable (perhaps if we count all the cases occurring in an epidemic it may be even exceptional), and the sequela of paralysis may occur in some cases of sore throat which have no claim to be called diphtheritic.

I will now proceed to mention, without much attempt at classification, the items of evidence which incline me to a firm belief in the propositions above stated.

A Rural Epidemic of Diphtheria.

About fifteen years ago I had the opportunity of observing for myself the facts as regards a village epidemic. The village, I may say, is an extremely healthy one, very straggling, and having many houses separated from each other by distances of a quarter to half a mile. Regarding most of the houses there is nothing whatever to be alleged against their drainage or water supply. Most of them are dependent on their own wells for water, and, as regards milk, it is from very various sources. The epidemic began in the central part of the village, and amongst school-children. Several deaths occurred in the course of a few weeks, a sanitary committee was formed, and the school was closed. After this the epidemic sore throat spread, I believe, to almost every house

in the neighbourhood, without any regard to rich or poor. I myself saw many of the patients, and some of them occurred in my own family, and others in those of near relatives. The total number of cases was not large, since the district is thinly populated, but of children I believe very few escaped. No case of death came under my own notice after the first two or three weeks of the outbreak, but several patients were extremely ill; many had abundant membrane-formations, and three or four cases of paralysis followed. Now whilst this was going on I examined repeatedly the throats of those who were suffering slightly. In some of these there was congestion only, no trace of pellicle; and in two or three some little strips of pellicle were observable for a day or two, and nothing more. The slightest cases were, as usual, in adults, and the most severe in children. The facts which came under my own eyes in this little epidemic are, I believe, with the exception of the early cessation of fatality, exactly what are usually seen in others. I have conversed with very many medical men in all parts of the country, and have endeavoured to collect their experience, and as a result feel quite justified in believing that when diphtheria is prevalent, there are commonly a great many sore throats due to its contagion which never show what are supposed to be its characteristics. I may add, in reference to the district which I have alluded to, that we have had, both before and since the little epidemic described, occasional cases of "diphtheria" and "croup," and that I have heard now and then of several children in a family suffering from sore throats which were presumably contagious. Many medical men resident in country districts have assured me that they were quite cognisant of similar facts, and that in an isolated farmhouse it might not infrequently happen that a sore throat would run through the family, concerning which it was impossible to be sure whether it should be called diphtheria or not. My inference from this is that the type of diphtheria may vary very much in different cases, that it is capable of originating in all localities and in all classes, and that it is only now and then that its contagious virulence becomes highly developed.

On the Real Nature of Diphtheritic Paralysis.

It is very important that we should entertain clear ideas as to the probable nature of the forms of paralysis which are often a sequel of diphtheria, and which constitute such a remarkable feature. We must not assume vaguely that they are any proof of blood-poisoning, far less that they necessarily denote a specific fever. In all probability they are purely local in origin, and are due to an ascending neuritis which starts from the nerve-endings in the affected mucous membrane. In this feature they have probably their analogues in a number of other diseases. Infective inflammations of skin and mucous membrane are liable always to result in the implication of the end-organs of the nervous system, and from them to travel upwards along the nerve trunks. Beginning as an affection of sensory structures only, they may, on meeting, by ascent along a sensory nerve-trunk, with motor-trunks or nuclei, implicate the muscular system. This is exactly what we observe in the neuritis of leprosy. In this disease the skin is invariably the part first affected. Its sensory structures are destroyed or greatly impaired by a chronic inflammatory action, and local numbness is the result. At this stage, however, another complication may occur, although it is very far from being invariable. The inflammation may travel upwards along the sensory filaments, and when these, in the case of mixed nerves, join with their motor companions, may by implication of the united trunk produce paralysis of definite groups of muscles. Examples of this are constantly seen in leprosy. It is, I think, exactly the same in diphtheria. Defects in sensation of the mucous membrane which has been involved are constantly present after severe attacks of the diphtheritic throat. When the membrane has cleared away, the patient will allow the pharynx to be touched without displaying any signs of irritability. In a large majority of cases this condition of partial anæsthesia gradually passes off, and no further complications ensue. This is just what is observed in the majority of cases of leprosic erythema. In a few cases of diphtheria, however, the process referred to, of ascending

neuritis sets in, and the proof that it has done so is afforded by the implication of certain groups of muscles, or even by a general limb-paralysis.

My own experience of post-diphtheritic muscular affections has been not inconsiderable in connection with affections of the eye. Next to paralysis of the pharyngeal muscles, and indeed in some cases when these latter have been but slightly or only for a short time affected, we have the implication of that part of the third nerve which is concerned in accommodation. The patients, who are apparently quite well, make their appearance at the ophthalmic hospitals or in our consulting rooms complaining that they are losing their sight, and have become unable to read. On examination it is found that a convex spectacle-glass entirely restores the reading power, the defect being due simply to loss of accommodation. None of the other third nerve muscles as a rule suffer. There is almost always the history of the patient having been troubled by fluids escaping by the nose. I have seen some cases of this paralysis of accommodation after very slight attacks of diphtheria, and a few in cases of quinsy or pharyngeal abscess, where presumably no real diphtheritis had been present.*

In all cases the condition after a few weeks' duration passes off, and this, I think, quite irrespective of any special measures of treatment which may have been adopted; nor have I ever met with cases in which relapses have occurred. The more severe and extensive forms of paralysis are far less common than the mild ones, but they obey the same law as regards being transitory and recoverable, provided only that the patient can be kept alive.

On the Non-Association of Diphtheria with Scarlet Fever.

In reference to the supposed association between scarlet fever and diphtheria, it may be asserted that the facts prove

* Dr. Mansel Sympson, in his interesting account of diphtheria as he observed it in Dr. Gee's wards in St. Bartholomew's, has the following important observation which fits well with the opinions I have expressed: "In epidemics, catarrhal diphtheria may occur wherein there is no formation of false membrane whatever. These cases may communicate diphtheria to others and may be followed by paralysis."

nothing more than that the one malady does not save from the other. Statistics might be quoted from all hands in proof that the two diseases do not show any tendency to prevail together.* Scarlet fever epidemics are not productive of epidemics of diphtheria. Yet coincidences of the two may not infrequently be observed, and it is quite possible that the scarlet fever sore throat may occasionally be attended by the formation of membrane. The experience of the metropolitan hospitals during 1890, with a total of nearly 37,000 scarlet fever cases, shows that only about two per cent. suffered from any form of throat ailment which could have been suspected to be diptheritic. It must be remembered also that these cases occurred during the prevalence of diphtheria in London, and in the hospitals into which diphtheria cases were admitted. In the Eastern Hospital during 1891, out of nearly 1,000 scarlet fever cases, eight developed chicken-pox, two measles, two whooping cough, and only one diphtheria.†

"Croup" a complication of Diphtheria.

As regards the use of the terms "diphtheria" and "croup," I observe that it is becoming the custom with many to give the former name only to cases attended with stridulous breathing and other definite symptoms of laryngeal obstruction. Thus "croup" becomes a complication or an occasional accompaniment of diphtheria.‡ In this sense the word is used in the Reports of the Asylums Boards. Thus on page 13 in that for 1890, I find it stated that albuminuria occurred in 14 per cent. of the total number of diphtheria cases; paralysis general or local in 12 per cent.;

* See ARCHIVES for October, 1892, p. 143.

† In reference to the influence of cold, &c., in causing sore throats, I am glad to observe that Dr. Hume, superintendent of the Northern Hospital, Winchmore Hill, insists on the importance of tar-paving for the courts. During the year no fewer than eleven cases of diphtheria had supervened in the convalescent patients under his charge, and he writes that he regards the "combinations of cold and damp as a potent predisposing agent to throat disease." For myself, I would rather write "efficient agent."

‡ It may be admitted that scarlet fever convalescents are prone to take diphtheria if exposed to its contagion. At the Northern Hospital, Winchmore Hill, during 1890, 2,611 cases of scarlet fever were admitted and 247 of

"Croup" in 8 per cent.; rhinitis in about 7 per cent., and Adenitis in nearly 3 per cent. Here then we see that it is in only quite a small minority of diphtheritic cases, even of those severe ones which find their way to hospitals, that definite laryngeal obstruction occurs. It is, of course, in the latter only that the question of operation can come into consideration.

"Closing" in Scotland a century and a half ago.

The parish of Kilmarnock preserved during the last century, beginning with 1728 (the birth-year of John Hunter), a very interesting record of its mortality. This register, originally kept by the parish schoolmaster, Robert Montgomery, has been made the subject of a very valuable analysis by Dr. John McVail, and supplies a most instructive chapter in the social history of the large towns of Scotland. Croup and diphtheria were registered under the expressive name of "Closing," and the facts given prove that they had during the last century a very considerable prevalence, and further that, in conformity with more recent experience, their prevalence varied very much in different years. Thus in the six years, 1734–40, "Closing" had only five victims. During a similar period, 1740–46, the number rose to 29. From 1746–52 it was 30, from 1752 to 1758, 33, while from 1758–64 it was only 9, or not two in a year. Thus it appears highly probable that during the 18 years '40 to '58 diphtheria maintained an unusual degree of prevalence, and destroyed, in a population which was perhaps not much more than 4,000, more than five lives annually. Its average mortality was indeed considerably greater than that of measles, and five times that put down to cancer. It did not, however, quite touch that of whooping cough, and was only one-sixth that of small-pox.

diphtheria. No fewer than 38 of the scarlatina patients took diphtheria, and of these 24 died, a fatality of 63 per cent. At the Stockwell Hospital, in contrast, during the same year, 1,003 cases of scarlet fever were treated, and not a single case of diphtheria occurred. The explanation offered is, that only during the last three weeks of the year were any diphtheria cases taken in. So also at the Fulham Hospital, where 130 diphtheria patients were admitted, no fewer than 33 of the scarlet fever patients contracted the disease, and 25 of these died. It is quite clear from such facts that the most careful isolation of diphtheria patients ought always to be observed.

Croup and Diphtheria in the London Fever Hospitals.

I have before me the Reports for the years 1890 and '91 of the Statistics Committee and Medical Superintendants of the fever hospitals of London. Into these institutions all the cases of diphtheria, scarlet fever, measles, etc., needing isolation away from the patients' homes, are admitted. And although I must still protest that I am not attempting to construct statistics, it may, I think, be not difficult to extract from them some very important items of information.

Tracheotomy in the London Fever Hospitals.

In the year 1891, the operation of tracheotomy was performed in the Eastern Hospital in 82 cases, and of these only 19 recovered. Sixty-eight of these patients had been admitted as diphtheria, and of these 18 recovered, while 10 were admitted with scarlet fever, which afterwards developed diphtheria, and of these only one recovered. Two were in cases where scarlet fever was followed by measles and diphtheria, and two were cases in which diphtheria had followed measles, and all these four died. In 25 of these operations it was resorted to immediately after the patient was admitted into the hospital, but in a stage which was almost hopeless.

In the New Cross Hospital, in the year 1890, twelve tracheotomies were done with one recovery, and intubation resorted to in sixteen cases with two recoveries.

Facts as to Contagion.

In evidence of the contagiousness of diphtheria, and at the same time of its usually non-fatal character in adults, it may be mentioned that Dr. Caiger, medical superintendent of the South-Western Hospital, reported for 1891 that seven of his officials had contracted diphtheria, presumably from their patients. All were adults, and all recovered.

Fatality from Diphtheria.

The mortality of 201 admissions into the Stockwell Hospital in 1891 was nearly 24 per cent. In the South-Eastern

Hospital the mortality was as high as 47 per cent. A very noteworthy fact in connection with this high mortality is that only one death occurred in a patient over ten years of age.

Dr. Bruce in the Western Hospital during 1891 recorded a mortality of 54 out of 151 cases of diphtheria, being at the rate of 38·4 per cent. In the previous year it had been only 22.

Concerning the New Cross Hospital, Dr. MacCombie records that during the year 1890 "one assistant nurse and one laundry-maid contracted diphtheria, and both died. Thirty officers were warded with tonsillitis." This statement well illustrates what has been said as to the impossibility of constructing diphtheria statistics. Those who (with myself) would feel unable to say of any case of tonsillitis occurring in a diphtheria ward that it was not the result of contagion, might incline to class these thirty cases as diphtheria, and to give a fatality of one in fifteen; whilst on the hypothesis that these were not diphtheria, the fatality rises to a hundred per cent.

Note on the prevalence of Croup in Scotland and Yorkshire a century ago.

In a letter from Dr. William Buchan to Mr. William Smellie (written at Sheffield, 1764) the following occurs: "I cannot make out from your account whether Dr. Hume's pamphlet on the Croup is wrote in Latin or English. If in the former, I think *suffocatio Stridula* a very proper name: but if he translates that into *Croup* he may keep his pamphlet at home; for I have never met with any one in England, either medical people or others, who called the disease by that name. Though that disease is very common here, yet should one speak of the Croup to a Yorkshireman he would believe you either meant the rump (crop ?) of a fowl, or the buttocks of a horse. The disease is, however, by no means sufficiently understood; and I should be extremely glad to be possessed of any good performance on the subject. Betwixt you and I, it does not matter a pin what name any man gives a disorder provided he points out the symptoms accurately, and proposes a rational method of cure."

I quote the above not solely on account of its philological bearing, but because it gives testimony to the prevalence of croupal affections in former times and the interest they excited. That large epidemics have been more prevalent and more fatal during the last half-century seems certain, but the more I have read in the writings of older observers, the more strongly I have become convinced that croup and diphtheria have prevailed as far back as medical history will take us, and they presented the same general features as at present.

Proclivity to common Catarrh ending at length in fatal Croup.

Auvert gives, in his magnificent Atlas, a delineation of membranous laryngitis from an adult. His patient is thus described:—"Vix quadraginta quinque annorum. Debilis et lymphaticæ constitutionis. Ex minimo afflatu aeris frigidi sæpe tussis catarrhalis symptomatis obnoxius."

The fatal attack of laryngitis, after which the specimen was obtained, was caused by exposure when insufficiently clothed. He died asphyxiated on the fourth day.

I give this extract and reference with much satisfaction because it supports, in the clearest possible manner, two of the statements which I am concerned to defend. In the first place it shows that the laryngitis of adults is membranous in exactly the same sense that "Croup" is so in children. In the second it affords an instance of a middle-aged man, who had long been liable to take cold easily and to have a catarrhal cough when he did take cold, finally becoming the subject of membranous croup. This last attack was induced by the usual cause, exposure to cold, and it probably differed from previous ones only in the greater degree of severity. I hold it to be a most important proposition that catarrhal inflammations may end in croupal ones.* Items of clinical evidence supplied, as in the case of Auvert's Plate, incidentally, and without any attempt to uphold a theory, are very valuable.

I have already mentioned several facts in proof that

* Dr. Mansel Sympson records of one of his cases, a child of 5, "for a week had a husky cold," and of another, "had a strangling cough and was sick" five days before admission. See p. 13.

diphtheria is often preceded by symptoms like those of a common throat cold. Statements of this kind may be found in almost every writer. They are of the utmost importance in reference to our creed as to the origin of the malady.

A House-Epidemic—Sudden death during convalescence.

The following letter, which I extract from the biography of William Smellie (the printer, not the doctor), affords evidence of the sameness of diphtheria in former days with what we observe at the present time. We see it prevailing as a family- or house-epidemic, spreading no doubt by contagion from one brother to the other. There is no reference to the disease being at the time prevalent in Edinburgh, and very probably it had begun in catarrh. Not the slightest attempt at isolation appears to have been attempted or even thought of. As an example of sudden death (from heart failure or embolism) during apparent convalescence from diphtheria, the narrative has also much interest. Exactly such deaths occur at the present time.

Mr. William Smellie to Mrs. Maria Riddell.

"Edinburgh, *February* 19, 1795.

"Dear Madam,—For several weeks past my family has been in a very sad condition. Five sons were all afflicted with dangerous sore throats. One of my sons, aged between nineteen and twenty, a good and useful young man, who from his cradle to his grave never vexed me, expired after an illness of five or six days. The rest, I hope, are in a state of convalescence.

"I am, &c.,
"William Smellie."

Note appended by Editor of "Smellie's Biography."

"The death of this promising youth was attended by the following particularly distressing circumstance. He had gone to bed at night with every appearance of being considerably better, and was considered as in a fair way of recovery. Henry Smellie, a younger brother, who lay in the same bed with Thomas, and was afflicted with the same

disease, thought proper towards morning to endeavour to awaken his brother, when, to his indescribable astonishment and horror, he discovered that Thomas lay dead beside him."

(*To be concluded.*)

[For some statements as to the operative treatment of diphtheria in Dublin, see ARCHIVES, Vol. IV., p. 20. For facts from Nuremberg and Munich, pp. 133 and 142 of same.]

NOTES FROM CONGRESSES AND CONTINENTAL HOSPITALS.

(*Continued from page* 145.)

A Case of Acute Lupus Erythematosus (with Erysipelas).

In a small, special ward under the care of Professor Schwimmer, in the Budapest General Hospital, my attention was especially called to the case of a poor woman who had been admitted a week or two before. She was about the age of thirty, and appeared to be very ill. We were told that her temperatures were variable, but usually high. In addition to Professor Schwimmer himself there were present at the consultation, MM. Hardy, Vidal, and Hallopeau, representing the St. Louis Hospital of Paris; Dr. Jamieson, from Edinburgh; and Dr. Radcliffe-Crocker, Mr. Malcolm Morris, and Dr. Pringle, representatives of the London School; besides many other dermatologists from all parts of Europe. Much interest was expressed in the case, but very few of us ventured to give any diagnosis. The peculiarities of the case consisted in that the patient had a very large patch on her neck and chest, which was tolerably abruptly margined and slightly scaly. The whole of her face was of a vivid red, and slightly but uniformly tumid. The swelling was sufficient to produce a little pitting, and to conceal her features. It did not, however, approach that of ordinary erysipelas.

It was difficult to get a very precise history of the onset of the disease. But there was no doubt that it had come on very rapidly, and equally little that for some time before the acute symptoms there had been present some skin disease on the face and chest. The conditions of the patch which had been

longest present, that on the chest, suggested to several of us a diagnosis of lupus erythematosus, and it appeared likely that the recent accession of acute symptoms was due to an attack of erysipelas spreading from these. The patient was very ill, and it seemed likely that she would die. The occurence of erysipelas in connection with all forms of lupus is well known, and that which attacks lupus erythematosus is occasionally very rapid in its spread, productive of great exhaustion, and followed by death. Of this I have seen several examples.

Ichthyosis in Streaks.

Amongst the more interesting cases which I saw in Professor Kaposi's wards in the General Hospital was a very good example of that form of Ichthyosis which is arranged in streaks, and of which I have given figures in Archives, Vol. III., Plates XLV. and XLVI. Most of the examples of this disease which I have myself seen, and they have been a very considerable number, have shown a distinct tendency to deviations from bilateral symmetry, and in many cases the conditions have been definitely restricted to one side (see Plate XLVI.) The more severe the condition, however, and the more extensive the changes, the greater the probability that both sides will be affected, and that there will be some approach to symmetry. The cases, however, always very definitely differ from the common type of xeroderma and ichthyosis in that the changes are not diffuse, and that some parts of the skin are entirely exempt and perfectly soft and normal. The common form of ichthyosis affects in greater or less degree the whole of the skin, and is, so far as my knowledge goes, always symmetrical. It is also usually a "family disease"; that is, if there be several children in the same family, more than one will be found to suffer from it. The form now under consideration, however, is, I believe, never seen with any family history whatever, but occurs as a sort of accidental arrest of the development of the skin, in a quite isolated manner to single children. The statements which I have just made will be easily apprehended by any of my readers

who will take the trouble to turn back to page 288 of Vol. III., near to which is Plate XLV., together with a tolerably full description. Plate XLVI., showing a much more slightly marked example of the same disease, will be found at the end of the same volume. Professor Kaposi's case offered the most severe example of this malady which I have ever seen. Its subject was a little girl of perhaps twelve years old. As far as I examined her the conditions appeared to be symmetrical, and they were very nearly, but not quite, universal. The arrangement in streaks was, however, very conspicuous, and there were some patches of skin which were quite healthy and soft. The parts which suffered most severely were the elbows and knees, the palms, ears, scalp, and arm-pits. These parts were roughened by the development of almost horny spines which were blackened by dirt. In particular the upper borders of her ears were crested over with growths of this kind a quarter or a third of an inch high. The horns, as far as I could judge, were in part due to papillary growth, and in part to sebaceous accumulations. The disease was so severe on the extremities as almost to disable the child from any use of hands or feet. There was no family history of tendency to skin disease. The conditions had of course been congenital, but had much increased since birth, and especially of late years.

Erythema-Scirrhus of the Skin in association with Cancer of the Breast.

Professor Kaposi had also under his care a very remarkable example of the rapid spread of erythematous cancer of the skin. The condition of "scirrhus en cuirasse," as it has been named, had developed over a large part of the trunk, and was rapidly increasing. It was in association, as usual, with cancer of the breast, and the statement was that the whole had been developed in the course of nine months. I may confess that this to me was almost incredible, and the women, on being pressed, admitted that she might have had the tumour in the breast for two years. She entirely denied, however, any longer duration. The erythematous infiltration of the skin was very superficial, and was attended simply by

redness with a slight degree of induration. Until touched by the finger the conditions might easily have been taken for a slightly-marked form of erysipelas, the spreading edge presenting much more vivid congestion than the rest of the patch. The patient, a woman of fifty-three, was of course confined to her bed; but she stated that she did not suffer much pain. The parts in which the disease was most advanced had undergone some contraction. I have never seen a case so extensively advanced with so short a history.

Scirrhus infiltration of the skin presents not infrequently very remarkable features. It has occasionally close resemblance, and even some analogies with lupus erythematosus. I have seen cases in which the early stage was nothing more than erythema, sometimes dusky and purple, at other times bright, and without the slightest trace of induration. It may be conjectured that in these cases, as in lupus erythematosus, the cell infiltration occurs chiefly in the perivascular spaces. The conditions are often so superficial and so purely erythematous, that they are difficult of recognition. Satellite patches of erythema are often, indeed very usually, seen near to the borders of the chief area. These are exactly similar to what we see so commonly in lupus erythematosus, in infective eczema and in erysipelas, and they are no doubt to be explained in these dissimilar diseases in the same manner—that is, by the spreading of infective cell-material in lymphatic or perivascular spaces. Most of the more typical examples of scirrhus en cuirasse—that is, those which fix the chest in a sort of board-like induration, spread, I think, very slowly, the disease occupying several years. The erythematous form of scirrhus may, however, spread much more rapidly, and of this Kaposi's patient, whom I have described above, affords a good example. I have quite recently been asked by a distinguished surgical friend to see, with him, a lady on whom he had operated about a year ago. The object of our consultation was to determine whether certain large red patches which had appeared on the mammary region were eczema or cancer. The patches in question had their bases at the line of cicatrix, and were advancing with abruptly-defined margins into the healthy

skin. Near to their margins were several little satellite blotches of erythema. It could scarcely be said that the patches had any induration, and the congested vessels could be emptied quite easily by pressure. I could, however, feel no doubt whatever that they were really examples of cancer-erythema. This opinion was partly based upon their resemblance to conditions which I had seen in other cases, and partly upon the presence, when the finger was lightly passed over the patch, of a slight degree of perceptible induration. I was interested by the information that at the time of the operation the skin was a good deal congested. Although the patient was elderly (upwards of sixty), the original growth had been exceedingly rapid in its progress. The tumour at the time of its removal was large and adherent to the skin, but its presence had been recognised by the patient only a few months.

Cases of Lupus-Elephantiasis.

Under the name of "Lupus tumidus" there were two magnificent models exhibited in the Congress Museum. In each instance the entire lower extremity was depicted. One of them was from the clinic of Dr. Hans Hebra, and the other from that of Dr. Lang. In each instance the entire extremity was involved in lupoid scar, with little patches of lupoid granulation structure scattered here and there. In each there was very considerable solid œdema, which especially affected the foot and ankle. These latter were very much enlarged, of elephantoid aspect, and covered with huge bossy masses of papillary growth.

These cases, of which I have seen several in English practice, although none perhaps quite so extensive, are of much interest as illustrating on one hand the tendencies of lupus, and on the other the way in which elephantoid hypertrophy is produced. They are usually cases in which lupus begins on the foot itself, and, in conformity with what is generally observed when lupus attacks the terminal part of an extremity, the disease is attended by much inflammatory œdema. The lupus, as lupus, spreads by its serpiginous

edge upwards, and may involve, as in the above case, the surface of the entire extremity. Meanwhile the solid œdema of the foot is slowly productive of its own series of nutritional changes. These consist not in anything of a lupus character, but in overgrowth. The persistent œdema and hypertrophy very usually receive repeated assistance from recurrent attacks of erysipelas, and a condition in no way distinguishable from elephantiasis is the final result. The epithet "tumidus," although well descriptive of a part of the process, by no means includes the whole, and the name Lupus-Elephantiasis is, I think, the only one really applicable. It is to be noted that in a few cases lupus of the extremities (of the hand rather than of the foot) results in exfoliation of bones and atrophy instead of overgrowth. To these cases, much more rare than elephantiasis, the term "lupus mutilans" is applicable.

Furuncular Diseases in Nuremberg.

Diseases of the furunculoid class are apparently very common at Nuremburg. No fewer than forty cases a year are recorded in the Nuremburg statistics at a hospital which records, in the same period, only ten cases of psoriasis. In addition to these about four cases of carbuncle are recorded annually, the subjects of which were all men. Under the name of furuncle, women bear a proportion of about one-third. During the year 1886 no fewer than 60 cases were admitted, 32 being men, 28 women. In addition to these we have to count a certain number, say 10 a year, treated in the same hospital in a special department for skin diseases. A very large number of cases also appear in the class of "phlegmonous inflammations," a family which includes phlegmon, erysipelas, lymphangitis, abscesses, and panaritium.

[I have pleasure in referring my readers to a very interesting account of the Vienna Congress of Dermatology from the pen of Dr. Jamieson, of Edinburgh, in the current number of the *Edinburgh Medical Journal*. In some instances Dr. Jamieson and myself have dealt with the same facts and cases.]

RARE FORMS OF ABDOMINAL TUMOUR.

I HAVE recently had under observation two cases which seem worthy of being placed on record as examples of very rare forms of abdominal tumour. In neither, as yet, has there been an opportunity for ascertaining the exact nature of the growth. They are not in any sense parallel cases, excepting in their being examples of what is unusual. In one the growth has been present half the patient's life time, and is clearly innocent, whilst in the other the presumption is strongly in favour of malignancy.

CASE I.—*An enormous Tumour of uncertain nature, possibly Cystic, and developed in the abdominal wall.*

An old woman whom I saw some months ago in the Whitechapel Infirmary was (and still is) the subject of a very peculiar form of tumour. It is an enormous rounded mass, and might have been taken at first sight for an umbilical hernia. It did not, however, begin at the umbilicus, but lay to its left side. The navel itself, which is shown in a rough drawing which Mr. Swainson did for me, is quite uninvolved, and a little displaced to the opposite side. The tumour could be lifted about from side to side quite easily, and might have been supposed to be developed in the abdominal wall had it not been that it appeared to receive a slight, but very decided, expansile impulse when the patient coughed. Against the idea of its being of a hernial nature, however, were the facts that it was not, and never had been, the least reducible, and that it was absolutely dull on percussion on all parts. On its front, and to the left, it had the consistence of a soft solid, though it might easily have been thought to fluctuate. To the right, however, it was very much softer, and as far as the

evidence of the fingers went it was impossible not to believe that it contained fluid in large, thin-walled cysts. An exploratory puncture had been made before I saw the case, but in the middle of the tumour, and not where, as it appeared to me, the sense of fluctuation was most distinct. The patient stated that the tumour had been gradually growing during half her life, and she was now between seventy and eighty. It had never been considered to be a hernia, and she had never worn a truss. A surgeon had once suggested its removal, but another had warned her strongly against it. It had never given her much pain or inconvenience, excepting from its size.

I publish the notes of this case thinking that possibly some of my readers may like to examine the patient. I dare not venture any positive diagnosis. It was through the politeness of Dr. Larder, the resident medical officer of the institution, that I saw the patient. She is still an inmate of the workhouse, and I have no doubt that Dr. Larder would be glad to allow any surgeon—interested in the attempt to make a diagnosis of a most unusual case—to examine it.

CASE II.—*A Multilocular Cystic Tumour in connection with the liver filling the abdomen—Repeated paracentesis—A Secondary Growth in the Neck.*

The condition of Mr. G—— may be briefly described as resembling that of a case of large ovarian tumour. He was, however, a man. The tumour filled his abdomen to about the size of the last month of pregnancy. It fluctuated freely, but the wave was not transmitted easily from side to side, thus suggesting a multilocular cyst. The surface of the abdomen was also quite different from that of ascites, the bulging being not evenly rounded, greater on the right side than the left, and the sides not being filled out in proportion to the prominence of the centre. Thus, from the first glance of the abdomen, I felt confident that we had to deal with an encysted tumour. It may be remarked that the parieties of the abdomen were thin and examination easy. The history given was that the enlargement had taken place gradually during two and a half years, and wholly without pain. The first bulging had been

noticed a little to the right and above the umbilicus. The patient was a man about thirty-seven, married, and the father of three children. He was a German by birth, but had lived many years in T——. He had not suffered from any special illnesses, but during the growth of the tumour, and especially of late, he had emaciated and become very sallow. His aspect was that of a patient suffering from malignant disease, and, although not distinctly jaundiced, he looked as if he had been so. As regards this point, it was difficult to know how much allowance to make for climate. He had but just landed when I saw him, having come over to England expressly for advice. He told me that he had been three times tapped. The first occasion was in October, 1889, when about a pint of fluid was removed. On the second occasion little or no fluid was obtained; but on the last, nearly two pints. This last was only just before he sailed, and, although it did not very materially diminish the size of the tumour, he thought that it gave him some relief. He had been liable to sickness before it was done, and this had entirely ceased afterwards. He had borne his voyage well, and was the better for it. Quite recently, that is within the last few months, a tumour had been detected on the left side of his neck. It was just above the clavicle and behind the sterno-cleido-mastoid. It was about the size of a child's fist, had apparently very thin walls, and fluctuated freely. The discovery of this second tumour seemed at first sight almost conclusive as to the infective and malignant character of the one in the abdomen.

The above notes were taken after an examination in my own room. I recommended our patient to become an inmate of a surgical home, and to let me tap him and make a further examination. The previous tappings had been to the right of the navel. I punctured him in the middle line, and probably entered the cyst, which had not been tapped before. We drew off about a pint and a half of an opaque, blood-stained fluid. It had a greenish tinge, and looked as if it contained bile. The tapping had the result of producing a depression in one part of the tumour, but it did not take away more than a tenth part of the mass, and it rendered it very evident, what we had supposed from the first, that the mass was composed

of many cysts. Some further details may be given as to the examination of the abdomen. The liver dulness appeared to be continuous with the tumour, but there was not the slightest lifting of the ribs or fulness in the region of the liver itself. The percussion note in the flanks varied from time to time. On one occasion it was distinctly tympanitic on the left side over a considerable area, but on several others it was quite dull. Although the tumour passed well down to the pubes, I thought I could find distinct evidence of an edge under which the finger could be pressed. The right flank was always dull. The resonance was quite clear over the region of the stomach. There had never, from first to last, been any urinary symptoms.

Examination of the fluid which had been removed revealed a great number of little shreddy masses of yellowish-white appearance, which easily settled down to the bottom. We used a powerful aspirator, and I had moved the end of the trocar about rather forcibly in the endeavour to enter other cysts. On the supposition that the tumour consisted in part of solid growth, these shreddy fragments might very possibly have been detached by the procedure described, which was at the time attended by distinct bleeding. The microscope did not detect any definite structure in the shreddy substance which has been described. In the fluid there were great numbers of very large compound granular cells. These varied much in size, were very conspicuous, and some of them very large indeed. The opinion which I formed from the above facts was that the tumour was developed from the liver, that it was a cystic formation, and probably of malignant nature. As the man had travelled a great distance for advice, and as I did not see my way to recommend any operative procedure, I suggested to him that, before returning, he should have the advantage of a consultation. My friend Dr. Barlow accordingly saw him with me, and as he agreed with me that it was not a case for operation, the patient returned to his home.

[I shall be much obliged to any of my readers who can inform me as to the sequel of this case.]

ON KELOID.

A DESCRIPTION is a very different thing from a definition. The one concerns itself with the external features of the object described, and is content to facilitate recognition. The other must go much deeper and must endeavour to seize those characters which are essential, but which, it is very possible, may not be attended by any conspicuous outward signs. It would be easy to describe Keloid as consisting of smooth, glossy growths, almost invariably developed in scars in the skin, and presenting the peculiar feature of having spurs running out from the edges of the patch. Such a description, more especially if helped by a pictorial illustration of a typical example, would enable any one easily to recognise all the well characterised cases. If, however, we attempt a definition of keloid we must take a much wider basis and must arrange for the inclusion of a number of forms which are distinctly not well characterised. Our definition might probably be,—An auto-infective fibroid hypertrophy of scar tissue. Under this definition we should have to describe several other forms very different in external appearances from the spurred and glossy growths which Alibert first recognised, and of which the peculiarities are now so widely known. The essential point concerning keloid is that scar tissue,—or tissue on its way to the formation of scar,—may take on a peculiar form of hypertrophy, which may prove very persistent and which, not restricting itself to the scar in which it originated, may grow into the adjacent skin. That the keloid growth possesses infective qualities is further proved by its occasionally producing new growths at distant parts.

It follows from these statements that inasmuch as scars differ greatly in their qualities and mode of origin so we must expect the keloid which results from them to vary.

So long ago as the year 1864 I wrote*: "Keloid appears to me to be essentially a disease of cicatrix tissue, and I much suspect that it never originates in normal skin." From that time onwards I have never believed that there is such a thing as "spontaneous keloid." Now that, by general usage, the term keloid is restricted to the scar form—the Keloid of Alibert—and is never applied to morphœa, we may, I think, suitably discard the terms "true" and "false" as having no signification, and with them also, so far as my own belief goes, the term "spontaneous." All keloid is true and all is cicatricial. In the case to which my remarks referred the disease was believed to have been spontaneous, but on careful examination and inquiry I had found numerous scars of small-pox, and obtained a history of a scald. In 1880 I was nominally a member of a committee of the Clinical Society which made a report on Keloid.† My colleagues, Sir Dyce Duckworth, Dr. Living, Dr. Radcliffe Crocker, and Dr. Goodhart, should have all the credit of this report, for I did no work in respect to it. At that time my own opinions were fully formed and had been repeatedly expressed. I had drawn attention to the possibility that such small scars as those of boils, acne, and small-pox might become the sites of keloid, and to the fallacy thus presented in that the patient might easily deny the previous existence of any scar. I had also expressed the opinion that all keloid growths exist under a law of limited duration, and that they all tend sooner or later to soften and disappear. In April, 1885, I published a Lecture‡ "On the conditions which precede Keloid, and on some rare forms of that disease," in which the above opinions were again discussed. If

* "London Hospital Reports," vol. i., p. 92. In 1887 I find that I wrote yet more strongly: "When I express the opinion that it never begins excepting in scar-tissue, that it is in fact a disease of cicatrix, I give you the result of careful clinical observation, and I am aware that I differ somewhat from previous writers." See the Fourth Volume of the same Reports.

† This report is embodied in the chapter on Keloid in Dr. Radcliffe Crocker's excellent work on "Diseases of the Skin," p. 482.

‡ See *The Medical Press and Circular.*

I now venture to return to the subject, it is because the subject is of great pathological as well as of clinical interest, and may, I think, be made to illustrate some very important laws.

Defining Keloid to be a fibroid hypertrophy of scar-tissue which is aggressive and in a feebler sense infective, the following propositions may, I think, be ventured respecting it :—

1. Although it is denied that keloid ever begins in uninjured skin, yet it is not to be doubted that it may originate in very small scars and spread far beyond their limits.

2. The cases which begin in small and scarcely recognised scars, although usually attended by very slow growth, show remarkable persistence.

3. There is a natural law of decline and final disappearance which attaches to all keloid, although the disease may in exceptional cases persist for twenty or thirty years.

4. It is remarkable that keloid growths, although infective in continuity, and thus serpiginous, show little or no power of reproducing themselves in distant parts unless scar tissues be there present.

5. If, however, old scars be present on distant parts, then the development of keloid in a new one may become the means of infecting some of the old ones and causing them to produce similar growths.

6. The important law just stated makes it probable that in all cases of keloid, infective germinal matter is shed into the blood, but that it cannot in healthy skin find a suitable home for development. The law is well illustrated by the case of a negro, which I published, in the London Hospital Reports, in whom many scars, left by cupping, which were quite healthy until keloid was produced by a scald, took on the disease afterwards; and also by a parallel case in which the scars of small-pox were affected in the same way as the consequence of infection from keloid in the scar of a scald.

7. Although keloid is possibly a near ally of sarcoma, and although some of its modes of growth resemble those of a malignant disease, yet it never takes on malignant action,*

* I am not aware of a single case on record in which cancer had developed in a keloid patch. Cancer of scars, on the contrary, is well known. I have seen

i.e., never ulcerates or fungates, or causes gland infection. When once keloid has softened and undergone resolution, it never returns.

8. Those cases in which the keloid forms immediately after the injury, and develops rapidly, are very hopeful as regards speedy involution. So also are those which occur in young persons, and those which are unusually extensive.

9. However long a keloid patch may have existed, there is still hope that it may go away.

I will now proceed to narrate some recent facts bearing upon the statements which I have just made. Others will be found in the Lectures to which I have referred, and also in papers already published in my ARCHIVES (see Vol. I., pp. 197, 335).

Large Keloid Growths in Vaccination Scars of twenty years' duration.—Satellites and Secondary Growths on Distant Parts.

Miss H——'s case is of much interest because it seems probable that the original keloid growths have proved infective. She was vaccinated for the first time at the age of nine, and the scars left at once took on keloid induration. She is now thirty years of age. From the vaccination scars long streaks with spurs have extended upwards and downwards. Other growths have also formed, two on the left shoulder within six inches of those on the arm, one on the left buttock and one small one in the scar of a burn in front of the right wrist. There is no proof that scars existed on the shoulder or buttock where the growths have occurred. She has also very small spots on the right shoulder and right hip. She is quite unable to assign the dates at which these secondary growths have formed. The burn on the wrist was only three years ago.

It appears that the vaccination keloids are softening and wasting, but they have of late become painful. She describes the pain as being occasional but very severe when it comes.

several cases in which it was exceedingly difficult to decide whether the disease was sarcoma, scirrhus or keloid, but they were always such as presented difficulties from the very first. I have never, I repeat, seen a structure which had been for a considerable period characteristically keloid pass into cancer.

She lays much more stress on it than on the itching. The newly-formed keloids are not either painful or irritable.

It is not quite certain that in this case the keloid lumps which formed in the vaccination scars have been the parents of all the others.* Whether the secondary growths have developed in uninjured skin or in scars which had been overlooked it is impossible to say. The keloid growth on the left buttock is a very well characterised patch a quarter of an inch thick, and as big as a florin. It is red and glossy.

It is of interest to note that the secondary growths appear to have developed rather separately and gradually, and at considerable periods after the original one. This is different from what we observe in multiple lupus, in which all the secondary formations usually occur as a crop immediately after the beginning of the parent one. That there is a considerable constitutional tendency on the part of the patient may perhaps be inferred from the facts that both the vaccination scars have suffered, and that the growths have extended to considerable distances into the sound skin above and below. It would appear that these original growths have now ceased to extend and are, indeed, undergoing slow involution. Miss H—— brings with her a pen and ink sketch taken by Mr. C—— seven years ago, in which they appear at least as large as now. In several parts they have recently thinned away. Miss H—— knows of no history of malignant disease or any kind of tumours in her family.

Subcutaneous Keloid Masses after division of plantar fascia.

In the case of a young lady who was the subject of pes cavus in connection with some form of infantile paraplegia, the plantar fascia had been divided for its relief. I saw her about ten months after the operation, and in each sole at the site of the operation there was then an ill-defined lump of considerable size adherent to the skin, evidently a kind of

* There is a possibility that the burn on the wrist (three years ago) may have proved an independent source of new keloid infection. This supposition would explain the anomalous features in the case. The dates cannot be given with accuracy.

subcutaneous keloid. The surgeon who had performed the operation had subsequently expressed a wish to excise the keloid indurations, but this had been wisely declined by the patient.

Cicatricial Keloid in three generations (father, daughter, and granddaughter).

An instance of the inheritance of tendency to cicatricial keloid came under my notice in the case of Mrs. M——. This lady had two large keloid patches of the most marked character in the middle of her chest between the breasts. She told me that one of them occupied the scar of an operation for the excision of a patch as large as a thumb-nail twenty-five years ago. The first growth had probably originated in the scar of a pustule. Immediately after the operation the scar took on the same condition, and soon advanced to five times the size of the first. For this she then consulted the late Dr. Tilbury Fox, who advised that nothing should be done further. Mrs. M—— told me that her father had suffered from the same disease in the same region, and that he had furnished the original for one of Sir Erasmus Wilson's drawings. His patch was, she said, much larger than her own. She added, "and one of my daughters has a patch also." I asked if I could see this daughter, and finding that she was sitting outside in their carriage, had her at once fetched in. She had a small keloid, recently grown, in the scar of a cut by a knife, just above her wrist.

White Keloid, with peculiar features, in the Scars of Boils (Sub-epidermic Keloid).

Miss R——, from Leeds, for whom ten years ago I excised a sort of sub-epidermic keloid patch from the left subclavicular region, comes to me again to-day (May 22, 1871). The scar, which is just midway between the sterno-clavicular joint and the nipple, is white and quite supple. There is not the slightest tendency to the return of the disease, nor has there been since the operation. All the needle punctures, however, are conspicuously marked with little discs of white scar. They are just a little raised, and can be felt by the finger; but there

is nothing in them approaching to a definite keloid condition. She still has on the shoulder, about half an inch below the tip of the acromion, a little white nodule of sub-epidermic keloid. It is about the size of a horse-bean. The epidermis over it appears to be almost healthy, although perhaps a little too smooth. It does not approach the glossiness of ordinary keloid; its margins are ill-defined, and it has nothing comparable to a spur. She tells me it was just its present size ten years ago. Both this and the one on her chest were developed in the scars of little boils. Both have been throughout quite white. She says that this little patch on the shoulder smarts, but does not itch, and she thinks it makes her shoulder ache. She tells me that in the original attack of boils, or impetigo, she had a number which left for a time little scars, but only these two finally took on the nature of keloid.

Two large patches of Keloid with somewhat peculiar features.

Dr. Foote, of Rotherham, sent to me in 1886 a lady of 39, in whom the history of scars was only indefinite. Sixteen years before I saw her she went through rheumatic fever with inflammation of the chest, and some time afterwards found a patch of keloid forming on a part where she had probably been blistered. She did not, however, take much notice of it for three or four years. When she came to me she had a patch over the middle of the sternum, oval, glossy, seamy, and very hard. There was another patch, seven inches long and three in width, under one arm. This latter was a quarter of an inch thick everywhere, and of a dusky-brown tint. It was not nearly so hard as the other was, indeed somewhat œdematous and slightly pendulous. Both patches were believed to be still growing. They were prone to itch and burn intolerably. Mrs. W—— was stout and in good health.

On the relation of Lupus to Keloid of Scars.

Common cicatricial keloid does occasionally follow the cure of lupus, but it is very rarely seen. The subjects of lupus do

not appear to be prone to organise scar tissue of the dense and hard character which constitutes keloid. Their scars do not easily become quite sound, and often present more or less of chronic inflammatory induration, but they are still far from resembling typical keloid. The latter occurs, I think, only where the healing has been completed rapidly, and is probably an indication of sound health so far as scrofulous tendencies are concerned. It belongs rather to proclivity to cancer than to scrofula.

In a few cases, very few, I have seen keloid in the scar of cured lupus. It has always been after unusually complete cure, and I think that the method by scraping is more likely to be followed by it than any other. The following are almost the only instances of the occurrence of which I have preserved notes.

Single small patch of Lupus in middle of cheek—Keloid after scraping.

Miss S——, *æt.* 23, was under my care in 1881 for a single small patch of lupus in the middle of one cheek. I scraped the patch. The cure was complete, but a little button of keloid formed in the scar.

On Lupus-Keloid.

Cases in which from the beginning a sort of lupus-process tends to the production of a keloid condition must be separated from those, such as the above, in which keloid follows the operative treatment of common lupus. Of this conjunction the two following cases appear to be examples.

Curious case of Lupus-Keloid in the chin of a girl.

A girl, *æt.* 15 (but looking like twenty), was under my care in March, 1884, and subsequently, for a very curious patch of lupus on the chin. It was about as big as a sixpence, and had very hard edges. It had no scab, being cicatrised and depressed in the middle. It was spreading at its edges. Its elevated edge was remarkably firm, and not very vascular, but in some parts spots of not very characteristic appearance

of apple-jelly-growth existed. It had been present nearly a year. Regarding it as lupus, I cauterised it freely with the acid nitrate of mercury. A month later it had quite healed, but the scar was still in a quasi-keloid condition. I saw her again three years later. The disease had not spread, and might be regarded as almost cured; but its edge was still elevated and bossy, like rodent on a very small scale.

It will be seen that it differed from common cicatricial keloid in having a depressed centre, and in the entire absence of spurs. Had it been in a senile person, I should have regarded it as an early stage of rodent.

Eczema-Lupus, partly Keloid.

A lady aged 62, in good health. She has a long patch crossing the anterior border of her left axilla. It is glossy, and a little indurated; *very red*. Abruptly margined, and the skin around it perfectly healthy. It is said to have been there five or six years, and it extends very slowly. It has no satellites. It is usually not in the least troublesome, but sometimes it inflames and becomes, from her description, eczematous. It is either eczema-lupus, or a minor form of keloid. There is no history of preceding scar, but it is just where her dress presses. It does not appear to be connected with the axillary hairs.

Case illustrating an Evanescent form of Keloid, and also its hereditary transmission.

There is a condition of keloid which is essentially transitory and of which, on that account, but little notice has hitherto been taken. In order, however, to make the pathological picture complete, it is essential to recognise it. Many recent scars are threatened with keloid induration during a few months after the first healing of the wound. At the end of six months or a year the tendency to growth has quite ceased and the cicatrix has softened down to at least level with the surrounding skin. These cases must, I think, be counted as the initial stage of true keloid, and it is to be understood that it is merely a question of intensity in the constitutional

tendency whether they develop into the more extreme and characteristic forms or not. Vaccination scars often for a time show this condition of things.

I have just had under my observation a case which illustrates the above statements, and, further, the hereditary transmission of tendency to keloid. A lady who had a keloid nodule in the lobule of her ear, which had been several times treated by excision and with invariable recurrence, bore an infant who was in due time vaccinated. During the year which followed vaccination and after the sores were soundly healed there was a distinct tendency to keloid growth in them. They even presented conditions which threatened the development of spurs. Towards the end of the year these formations melted away, and at present the scar is level with the skin, although still harder than natural.

On Prurigo-Keloid.

Having shown that keloid may attack scars which are in themselves exceedingly small—such, for instance, as those left by boils, acne, or blisters—I have next to make the proposition that certain conditions, in which scratching is the principal element, may be attended by keloid formations of a very peculiar nature. It is well known that pruriginous affections, in which habitual scratching has been practised, are apt to be followed by scars. Thus the skin may in some of these cases become marbled over with little white cicatrices. I have described this condition in detail in connection with the disease which I have ventured to name summer-prurigo. The step which I now wish to take is that of recognising that these little scars—the results in some cases almost solely of the use of the patient's nails—may become affected by keloid growth. When such is the case the patient may be mottled, over large tracts of skin, with little keloid nodules. The keloid in such cases presents peculiar features, and rarely, I think, shows much tendency to grow. I am speaking from the observation of but very few cases. As yet it has never happened to me to witness the formation of spurs or of any material invasion of the healthy skin. The little buttons are

almost always conical, or at most bee-hive shaped, and they seldom become either glossy or red, yet that they are of the nature of keloid according to the definition which has been attempted above, that is, fibrous indurations in scar tissue, I have no doubt. Although I have seen several other less well marked examples of this condition, I have in memory only three which can be regarded as typical and well characterised. Of these the first was brought to my notice by Dr. I. Mennell Williams, late of York, in the person of a lady who had for long been under his care on account of an obscure lichenoid eruption. This eruption had been most severely scratched, with the result that a large crop of keloid nodules had been developed. These were especially abundant on the arms and shoulders. It is many years since I saw this patient, but I well remember the very peculiar features of the case, which were at that time quite new to me. My second and third cases came under my notice almost together, and within the last year.

One of these I record in detail below, and the other was brought under my observation by Mr. Morrant Baker. The conditions displayed by Mr. Baker's patient are well illustrated by a model, photograph, and coloured drawing, which have been preserved in the collection of the Royal College of Surgeons. Mr. Baker's patient was a woman of about thirty, and her condition had claimed the interest of all who had seen her. I believe I may add that none had ventured to give to her eruption any special name. The eruption consisted in little dome-shaped indurations, varying from the size of a pea to that of the end of a forefinger, and scattered over the chest, arms, legs, &c. Many of them on their summits bore evidence of scratching, and all of them were at times intensely pruriginous.

A Pruriginous state of Skin attended by Vesications and Abortive Pustules, and resulting in the formation of scattered Keloid Nodules of Conical form—Duration seven years.

The case of Mrs. W—— offers, I think, in some respects, a parallel to the important one recorded by Mr. Morrant Baker.

It is complicated by a tendency to other forms of skin disease, but in the main feature, the production of little conical indurations in the skin, the two are alike. In both cases the indurations occur chiefly on the backs of the forearms, arms and hands, and on the fronts of the legs. They are symmetrical. Mrs. W——, wife of a clergyman, is now 53 years of age. She is thin and pale, but not specially out of health. All her life she has had an irritable skin, having suffered, as she thinks, much more than others from fleas, mosquitos, and the like. She was one who "was always sure to get a flea if there was one about." They used to produce urticaria-like wheals, but she does not think she was ever the subject of spontaneous nettle-rash. She could never wear woollen next the skin. Notwithstanding this susceptibility Mrs. W—— enjoyed, she tells me, a clear complexion, and entire freedom from persisting skin disease until about seven years ago. She then became liable to her present affection, which has lasted, in spite of treatment, ever since. Six years ago she was for a considerable time under the care of Mr. Windham Cottle, and subsequently, having been told that her affection depended on gout, she consulted Sir Alfred Garrod. Since then she has tried very various remedies, but without effect. When her affection commenced she was living in England, but she had previously spent many years in India. In 1866 she had suffered an attack of jaundice, but she does not remember that it was productive of any increase in the irritability of her skin. The condition for which she consulted me began, as stated, seven years ago, and as far as she can recollect its commencement was a little irritable spot on one arm, which was soon followed by a similar one on the other. She had no idea that she had been bitten and did not recognise any special cause. After this spots came over all her limbs. The irritation was intolerable, and she spontaneously described the sensation "as if there were a little seed in the skin which I must dig out with the nail." The final result had been that her arms and legs became covered with little conical indurations, all of them presenting abraded tops. Some of them are as large as the tip of the little finger. There are also some abrasions without induration, and the skin generally has

assumed a dry condition with, in places, a tendency to diffuse eczema. The skin of her face generally is dry and so is that of the backs of her hands and fingers, with many little erythematous spots and a slight tendency to crack. Her face, as well as her limbs, is irritable, and has been much scratched and rubbed. She said that in some cases little watery blisters would occur as the result of rubbing on the limbs but that they soon broke and were followed by the deep-seated indurations which have been above described.

A case of Prurigo-Keloid recorded by Dr. Hardaway, U.S.A.

I have just found in the "American Archives of Dermatology" for 1879, a case recorded which, had I seen it, I should probably have claimed as belonging to the group of prurigo-keloid. The patient was brought before a medical meeting by Dr. Hardaway, and her case excited great interest. No name was given to the malady. As in my own and in Mr. Baker's cases, the patient was a woman. She was fifty-one years of age, and had suffered for twenty years. The prurigo was intense. The little nodules occurred chiefly on the extremities. In strong confirmation of the diagnosis of keloid, one growth (excised for microscopic purposes) recurred in the scar of the wound.

(*To be concluded.*)

SYPHILIS.

No. XLII.—*Lupoid destruction of Alæ Nasi, with loss of Septum—Difficulty in diagnosis between Syphilis and Common Lupus.*

April, 1892.—Mrs. B——'s case was of importance on account of the difficulty of diagnosis between common lupus and the syphilitic form. Her nasal septum was extensively destroyed, and the tip and alæ in part removed by ulceration, and in part concealed by being doubled into the nostrils. One ala, a loose flap, was turned completely into the left nostril, and might be drawn out and put into place. This condition is not uncommon in syphilitic ulceration, but unknown in lupus vulgaris. The character of the existing ulceration on the upper lip and right ala was also exactly like that of syphilis, and not like that of lupus. By this I mean that it was an inflamed ulcerated surface with a pus-crust, but with little or no granulation growth.

There extended upon her cheeks large, ill-defined patches of dusky erythema. These might pertain either to syphilis or lupus vulgaris, but there was nothing in them characteristic of the latter.

Mrs. B—— was a widow, a schoolmistress, of about 50 years of age, and she had suffered from the lupoid disease several years. She was a very sensible person, and I ventured to ask her a direct question as to syphilis. She understood my inquiry, and told me in reply that she had no reason to think that she had ever suffered. She had no indications of taint that I could discover. A condition which favoured the diagnosis of common lupus was that of her gums. Those of her upper jaw were swollen and ulcerated

exactly like lupus, and not like syphilis. I treated the case by a liberal cauterisation with the acid nitrate of mercury, and gave iodide of potassium internally. The cauterisation was repeated, at intervals of ten days, two or three times, and with the result that in the course of six weeks the parts were soundly healed. The erythematous patches on the cheeks had also almost entirely disappeared.

I do not feel any doubt that this case, although corroborative history was entirely wanting, was really one of syphilis. We do not get such rapid and complete cures in common lupus. It will be seen also that the appearances described favoured strongly the diagnosis of syphilis. I record the case, and have described the appearances in some detail, because the differential diagnosis illustrated is one of very great importance. Scarcely a month passes without my seeing a case in which treatment has been conducted for years on the hypothesis of lupus, but which is cured at once on changing to that for syphilis.

No. XLIII.—*Some unexplained facts as to the influence of Sex in inherited Syphilis.*

There are some curious facts as regards the greater liability of the female sex to the later results of inherited taint. My attention was first drawn to them when writing on Iritic Keratitis in 1863, and although they have since then been confirmed not only by my own more recent experience, but by many other observers, no plausible explanation has been offered. The inequality referred to does not apparently obtain in the case of deaths from syphilis in infancy, nor as regards the prevalence of inherited taint in general, but only in reference to certain special affections.

The mortality at the Blackfriars Hospital for Skin Diseases is mainly caused by hereditary Syphilis. Its total is, however, very small. I find from our book of certificates of death, that, during a period of nearly twenty years, only seventy-one such certificates have been given. Of these, however, no fewer than forty-one were for Hereditary Syphilis, and several others are so worded as to leave the question doubtful. Of

the forty-one alluded to, twenty-two were boys and nineteen girls. Thus it would appear that the number of boys who die of infantile Syphilis at least equals that of girls.

In my work on "Inherited Syphilis as a Cause of Diseases of the Eye and Ear," I published a considerable number of cases of Iritis in infancy, and of Keratitis and of Deafness at later periods. On counting the whole of these up, it would appear to be the fact that the female sex presents a considerable excess of subjects of each of these forms of disease.

My facts stand as follows :—

Of Iritis in infancy, twenty-three cases in which the sex is specified, and of these eighteen were females and only five males.

Of Keratitis at various ages before and after puberty, but none in infancy, a total of one hundred and two cases, out of which sixty-four were females and only thirty-eight males.

Of Deafness at various ages (no infants), there are twenty-one cases, of which fifteen had Keratitis also, and are counted in the preceding statement. The subjects of the six cases not counted in the Keratitis series are all females, and of the fifteen so counted nine were females and six males. Thus we have totals of fifteen and six respectively.

My book also comprises, in addition to the cases included under the preceding statements, twenty others, in which for various ailments children or young persons, the subjects of inherited Syphilis, came under care. These were of various ages, but most of them beyond infancy. Of the twenty, thirteen were females and only seven males.

Mr. Hinton states that cases of deafness in connection with hereditary Syphilis constituted one-twentieth of his patients at Guy's Hospital. He gives no statistics as to sex, but states : "The great majority of cases that I have seen have been in females." *

The most recent contribution to the statistics of the subject occurs in Mr. Brudenell Carter's Lecture, published in the *Lancet* for the 17th of December ult., page 1374. Mr. Carter gives as his experience of Interstitial Keratitis ninety-two cases, stating that he regards them all as resulting from

* Page 461, Toynbee on "Diseases of the Ear."

inheritance of taint. Of these, sixty-one were females and only thirty-one males. As regards ulcers of cornea (not syphilitic), the proportions of the two sexes were equal.

No. XLIV.—*The complete success of the Abortive Treatment a source of dissatisfaction to patients.*

Patients in whom the abortive treatment has been successful not infrequently come to entertain a suspicion that, after all, they have never had the disease. Such was the case in the following instance. Mr. W. E. A. called on me with the express purpose of obtaining an opinion as to whether he had had the disease or not. His facts were as follows: He was exposed to risk (on a single occasion) on January 2nd. He noticed nothing until five weeks later, when there was some irritation which resulted in two little sores in the under surface of the prepuce, near the corona. These he showed to a medical relative two weeks later, who told him they were chancres, and advised him to see a specialist. This he did a week later, that is, two weeks from the appearance of the sores and seven from the date of contagion. Mr. Buxton Shillitoe pronounced them hard sores, and said that he feared that it was too late to prevent secondaries. At this time the two sores were large and quite distinct from each other. Mercury was at once prescribed—a grey powder pill three times a day. In eighteen days the sores were healed, and in five weeks from the beginning of treatment not a trace of either remained. The pills were continued, and for a time were taken four times a day. At one time there was slight ptyalism. From first to last no eruption on the skin and no trace of sore throat appeared, and when Mr. A. came to me after nine month's treatment, he was wholly free from symptoms, excepting some slight enlargement of inguinal glands. I, of course, told him that he had certainly had infecting chancres, and that he was indebted to the treatment for his escape from secondaries.

I publish the above case, not as an example of what is rare, but of what is very common. Those who practise the abortive treatment must look to encounter not infrequently

very hesitating gratitude on the part of their patients. The popular idea of syphilis is that it is necessarily attended by a loathsome eruption and great loss of health. When the chancres pass away and nothing whatever follows, the patient begins to suspect that there has been an error. He cannot believe that a few boxes of little pills have really prevented so much. He has saved his fees, his health, and very likely his reputation; but he is quite unable to realise his obligation, and as frequently becomes rather suspicious of a blunder than grateful for skill. This unfortunate result is of course especially likely to occur if the surgeon be one not engaged in special practice. I therefore strongly advise all who use this method to explain fully that it is designed to prevent all consequences, and that probably with the disappearance of the chancre there will be an apparent end of the matter. In future years the abortive treatment will also render the recognition of a syphilitic history, in cases of remote tertiary disease, a matter of much more difficulty than at present. We now, in taking a patient's history, rely much upon the previous occurrence of what we know as "complete syphilis," meaning by that expression a chancre followed by rash and sore throat. In the future very few cases will have this "complete" record. Almost all will tell us, "I once had a sore which Mr. —— said was a chancre; but it was soon well, and for my own part I do not believe it was one."

RHEUMATISM AND GOUT.

No. XXII. — *A case illustrating the distinctions between Rheumatism and Gout.*

The case of Mrs. N——, a very intelligent lady of 48, is of interest in reference to the distinctions between rheumatism and gout and also as to their coincident occurrence. It affords, too, a good example of the attacks of acute rheumatic gout which simulate rheumatic fever. Several of her relatives had suffered from true gout, and many from rheumatism. In particular her paternal grandfather had had many attacks of gout, and his son, her father, several of rheumatic fever. Mrs. N—— herself was a stout, rather florid lady, of not very vigorous health. She had been through life liable to quinsies, and she associated the quinsies in some way with her rheumatism, believing that a quinsy had often preceded a rheumatic attack. She had also in early life been very liable to "catch cold," in the ordinary sense. Of late this had very much ceased, and she thought that proneness to rheumatism had taken its place. She never, even in early life, could digest malt liquor, and she had never taken wine regularly. Many years ago she had an attack which was called rheumatic fever, from which, after the usual duration, she recovered. Her recent attacks, of which she had had two, had been called rheumatic gout. One of these, two years ago, had confined her to bed six weeks unable to move hand or foot, and the last, six weeks ago, from which she had but just well recovered when I saw her, had kept her in bed ten days. I asked her how she distinguished these attacks from that of rheumatic fever, from which she had suffered in former years. She said that they had both begun definitely with gout. In each instance she described

as the first symptom a red glossy thumb, adding, "You know gout becomes red, but rheumatism doesn't." In these two latter attacks she had had much swelling about the carpus, and this had persisted for some time after the general rheumatism had ceased. All the smaller joints of her hands had also suffered during these attacks of generalised rheumatic gout, although the larger ones had also been implicated. There had also been great difficulty in perspiration, and she said that hot-air baths had been used with very little success in that direction. During the debility of her convalescence, however, the slightest thing made her perspire. From these attacks of acute rheumatic gout the recovery had been very complete; not a single joint had been stiffened or left permanently swollen. "When I get well, I get well," was her expression. The only exception to this statement when I saw her was a certain amount of thickening about the right carpus. There was no evidence of affection of the heart. Mrs. N——'s reason for consulting me was that she was suffering from rheumatic pains in various parts, and that her hand, as stated, was still swollen. She held that during the attack she could distinguish between gout and rheumatism in her different joints. She said that the pain was different. I asked which was the worst, and she said she thought the rheumatic. The gout joints, she said, felt sore, but they did not ache so terribly as the rheumatic ones. Her verdict on this point differs from that popularly received. It must be remembered, however, that she had not suffered from really severe gout. As regards the minor forms, I have no doubt that her expressions were quite correct. Sub-acute forms of gout, infinitely more common than the very severe, are not extremely painful, and they are attended, as she described it, by a sense of soreness rather than an aching.

I have to add to the above narrative, that Mrs. N—— did not consider herself very susceptible to weather, and did not usually know when the wind changed; she believed that she had formerly for some years prevented the joint pains by the habitual use of lime-juice at her meals. Having been told that it was debilitating, she had unfortunately left i off.

My theory in explanation of such a case as the above is perhaps a little complicated. In the first place, I should think there is little doubt that the patient has a double inheritance—first, of defective digestion and assimilation tending to the accumulation of urate of soda in the blood (= gout); next, an inherited susceptibility of the nervous system and tissues generally, involving a liability to general arthritis on exposure to the causes of cold-catching (= rheumatism). In explanation of the occurrence of acute generalised attacks, I invoke the theory of the infectiousness of the products of inflammation. The joint first inflamed probably furnished to the blood elements which infected other joints, and so on; the more that were infected the greater was the risk of further increase. This is the law which, so far as I can see, probably underlies almost all forms of inflammation, whether of the skin joints, mucous or serous tissues, which tend to become rapidly generalised. They are in a certain small degree analogous to the exanthemata, and the poisons which produce them, although not specific, and although accompaniments and products of the inflammatory process, are yet capable of self-multiplication in the system and enjoy only a limited duration of vital activity. Thus an attack of rheumatic fever, or one of gout, or of any like inflammation, tends to come to an end spontaneously with a certainty only slightly less than that which we note in smallpox or measles. In the case just recorded, the patient, it will be noted, asserted that her earliest symptom was a gouty inflammation of her thumb. From this a generalised arthritis, in part gouty and in part rheumatic, rapidly followed. That this generalised attack should be in the main rheumatic, or at any rate not definitely gouty, fits well with the theory which I have ventured to propound. An inflamed joint may easily be supposed capable of supplying to the blood elements capable of producing arthritis elsewhere, but it could scarcely increase to any material extent the quantity of urate of soda circulating in the blood, and it is upon the latter that the differences which we regard as distinctive between gout and rheumatism mainly depend. In all generalised attacks it must follow,

therefore, that the special phenomena of rheumatism will preponderate over those of gout. If gout be really severe and well characterised, it restricts itself to one, two, or, at most, a few joints, because its specific poison is not capable of indefinite increase. If the arthritis becomes generalised, or makes any approach to being universal, the gout peculiarities become merged and lost in those of rheumatism, for the rheumatic elements, as suggested, are capable, indeed are prone to, quite indefinite multiplication. Thus gouty proclivities, by starting a local arthritis, may become the parent of rheumatism.

No. XXIII. — *Severe tophaceous Gout—Enormous chalk-stones on hands—Minute tophi in the substance of the irides near their ciliary margins.*

A man named W——, an inmate of the Kensington Workhouse, who was shown to me by Dr. Potter, the resident physician, offered a good example of almost uncomplicated gout. He had very large chalk accumulations in his hands, which quite crippled him. His age was 42, and he had been an ostler. His father, who was a brewer, had died of gout. He was, excepting his liability to attacks of gout, in good health, and he had never had rheumatism, in any definite form, apart from gout. The tophi on the backs of his hands were as large as a child's fist—the largest, I think, which I have ever seen. His feet were similarly affected, but none of his larger joints were stiffened. There were, however, exaggerated osseous lips on the condyles of his femurs. There were no tophi in his ears with the exception of one on the back. The eyes in this case presented a very noteworthy condition (portrait taken). They were exactly alike. Near the corneal margin of the iris were a number of little wedges of white about as big as pins' heads, but angular in outline. They were not seen in the upper part of the iris, where covered by the upper lid, and were very small and few in number at the lower border, where partly covered by the lower lid. They were largest exactly opposite the commissures of the lids. I have no doubt that they were urate of soda, and it

is interesting to note that exposure to light had probably had much to do with inducing their deposit. No inflammation of the eyes had ever occurred, and the deposits in question caused not the slightest inconvenience. They had been first observed by Dr. Potter, who drew my attention to them.

No. XXIV.—*Lumbago and Aural Pruritus with Seborrhœa in their association with Gout.*

V—— de B——, a German wine-grower, came under treatment on account of a modified form of lumbago. He was a tall, finely-developed man of nearly 50. He was accustomed to drink both claret and champagne, but told me, on my advising him to abstain totally from the latter, that he was well aware that it did not agree with him, but that in the course of business he was almost compelled to drink it. The peculiarity of his lumbago was that he thought that it was increased rather than made better by exercise, whereas lumbago, as a rule, is got rid of by active exertion. I am not sure that in this instance the patient was correct in his impression, or that he had really walked with sufficient energy. His lumbago, he said, was always worst in the evening, and although he chose to think that this was due to his having walked about in the day, it might easily be that the real cause was the champagne taken at dinner. His lumbago had not been severe, and he described it as "a slight, sleeping pain," which always kept him in anxiety lest it should get worse. On only one occasion had he had anything which could be considered as definite gout, and then the attack, which consisted in pain and stiffness in the great toe, had but a very short duration. He had, however, often been threatened by pricking pains in the thumbs and other joints, and he had often seen uric acid in great quantities. Thus I think it may be assumed that he was unquestionably gouty. My interest in this case begins with the proof of the existence, in varying intensity at different times, of true dietetic gout. With this I wish to connect a symptom which has received

but little attention. I refer to the occurrence of a pruriginous condition of the external ear, associated with which was occasionally a definite seborrhœa and transitory deafness. I have met with this repeatedly, and feel sure that it is a symptom and result of latent gout. It is important to prove this, for if gout can cause seborrhœa of the ceruminous glands, it may be competent to the production of seborrhœic eczema, and other disturbances of the sebaceous glandular system. There is still much debate amongst dermatologists as to whether gout has anything to do with eczema. For my own part I have no hesitation in answering such a question in the affirmative. Although most cases of eczema are chiefly due to local causes in their origin, and all cases are undoubtedly due chiefly to local causes for their aggravation and persistence, yet I hold most firmly that constitutional influences take their share in the process. When the blood is gouty, the skin is irritable; in many persons a slight error in diet in the direction of gout will make the skin in certain parts itch intolerably. With this pruriginous condition there is very apt to be associated local activity in the sebaceous glands; or, if this be not present at first, it may be easily produced by the scratching which the pruritus induces.

To return to the subject of seborrhœa of the ear in its association with gout. The patient, whose case I have mentioned above, is only one among many who have complained of temporary attacks of deafness, and have said that these were usually associated with a moist, sticky discharge. Attending this discharge, and usually preceding it, was intense irritation deeply seated in the auditory canal. That the discharge is the ordinary secretion of the ceruminous glands its stickiness, colour, and smell all combine to prove. The discharge is always very much increased in quantity if the patient yields to the impulse to put his little finger into his ear. Our patient in the case narrated had suffered repeatedly from these conditions, and he was very clear in his testimony that the attacks always occurred when he knew from other symptoms—pains in his joints, the appearance of uric acid, &c.—that he was gouty. As his case presented no peculiarity in this respect, I may here leave it,

and may narrate another yet more definite in proof of my position.

A member of our own profession, and an accurate observer, has been good enough to supply me with the data of his own case. He inherits a tendency to gout, and has suffered repeatedly from slight attacks of pain in the great toes at night and in the thumb joints. He has also often seen uric acid in abundance, and is very susceptible to errors in diet. Although he lives by rule, he is obliged to live well, being one of the many who aver that they never feel up to their standard of tone unless they are on the verge of gout. To go to the edge of the precipice, and not to fall over, is his favourite problem. Now this gentleman has been troubled much and often by seborrhœic otorrhœa. His attacks always occur in conjunction with other symptoms of gout, and they are always remedied by increased care in diet, and the use of alkalies. The symptoms begin by intense itching deep in the external ear. It is, my friend asserts, impossible to avoid the application of the finger, and this soon causes the discharge of fluid wax. If the condition be neglected, and especially if the finger be used more vigorously than ordinarily, the ear may be made to throb, and an attack of general inflammation of the canal may be threatened. Attendant upon this condition, after it has lasted some time, there is usually heat, slight tenderness, and stiffness of the whole of the cartilage of the external ear.*

In the case of my friend, deafness, sometimes to a very troublesome extent, often attends the seborrhœa condition. It does not appear to be wholly, or even chiefly, caused by the blocking of the canal by secretion, and it is persistent in greater or less extent in the attacks. I suspect that it is in connection with implication of the joints of the bones of the ear in the processes of rheumatic gout. In the case to which I am now referring, entire immunity from the liability to pruritus and seborrhœa has been repeatedly attained for a

* I believe that Sir Dyce Duckworth has described the condition of stiffness and induration of the cartilage of the external ear in connection with gout, and I have little doubt that this state is the final result of neglected attacks such as those which I have described.

period of a year or so at a time. There is, however, invariably a recurrence unless the greatest possible care be exercised in reference to wine and fruit.

No. XXV.—*On the possible association of Herpes Zoster with Gout.*

It is a question of much interest whether the peripheral neuritis which produces shingles is ever itself of gouty origin. A considerable number of the severe cases of ophthalmic zoster certainly are met with in elderly persons of gouty proclivities. It is at the same time undoubted that many of them are in no such association.

An old gentleman of nearly 80 consulted me on account of the state of his arm, which was quite crippled as the result, he said, of an attack of shingles. His fingers were wasted and stiff, and his thumb was bent over towards the palm, and seemingly anchylosed at its carpal joint. It might be that these changes were in part the result of his having had the hand kept for some time in splints. It did not appear probable that he would ever regain the usefulness of his hand. The wrist itself was involved in the stiffening, but not the elbow. Mr. —— was in very good health, with the exception—if it be an exception—that he was gouty. The account which he gave of his illness was that, whilst confined to bed with gout in the great toe, he was one night awakened with pain, about the left shoulder, of a severity which he had never before known. This pain persisted for a day or two, and was followed by an eruption which his medical attendants called zoster on the front of the upper arm. After this the whole of his hand was swollen and painful, and it was placed in splints, which were continued for some weeks. It did not appear that the eruption of herpes had been very severe or unusually extensive, and it had not left any scars. It was exceedingly difficult to say how much of the present muscular defect in the hand and forearm was due to herpetic neuritis and how much to rheumatic gout and stiffening from disuse. It appeared perfectly clear, however, that a sharp attack of herpes had occurred during one of gout.

No. XXVI.—*Severe Tophaceous Gout—Osteo-arthritis and much crippling of lower limbs.*

A man named S——, an inmate of the Kensington Infirmary, presented a remarkable example of the formation of tophi. His hands were quite disabled by them. At various parts on his fingers, knuckles, and backs of hands, were accumulations as large as walnuts, the yellowish-white tint of which showed through the thinned skin over them. His feet were also affected, and his ears were speckled over with spots of chalk. He walked very badly indeed, shuffling along as if both legs were stiff. I thought his knees must be anchylosed, but found that neither they nor his hips were fixed, although a good deal stiffened. This man held that he had gout only, and that he had never had rheumatism. That osteo-arthritis took a share in his case was, however, quite certain from the development of most conspicuous lips on the condyles of his femurs.

This man was, excepting his severe gout, in good health. He had been born in Suffolk, but had come to London at the age of 19, and, working in a foundry, had drank beer freely. His first attack of gout was at the age of 29. A brother of his had gout, but he did not know of any inheritance.

Note on the State of the Teeth and Nails in Gouty Persons.

I examined the teeth and nails both in this patient and in the subject of the preceding case. The teeth in both were in a most unpleasant condition from coating of soft tartar and accumulation of greenish mucus. They had, of course, been absolutely neglected, owing to the crippling of the patients' hands. In neither patient were the nails hard or polished. In the man Stiff, they were indeed somewhat fibrous, but he had suffered from acro-arthritis, and probably they had shared in inflammatory irritation. I mention these facts because I believe that there is some impression that the teeth of the gouty present peculiarities. I do not believe that they do, unless, indeed, we consider that not unfrequently they are more than usually sound, and that the saliva is especially prone to deposit tartar.*

* Hence, perhaps, the proverb : "You've got a good set of teeth ; mind you don't dig your grave with them."

As regards the nails in gout, it is certainly, I think, often seen among the better classes in England that those who are gouty have very good nails—thick, solid, transparent, and and brightly polished. I am quite aware that this type of nails is often also seen where there is no gout. They imply, as a rule, sound tissues.

No. XXVII.—*Recurring attacks of Congestion and severe pain in the Eyes in connection with Gout.*

I described many years ago, under the name of "Hot-eye," attacks of temporary congestion of the eyeball which occur in connection with gouty dyspepsia, and of which the principal symptom is a sense of heat. The attacks described often come on very quickly after an error in diet, and are usually very transitory, lasting, it may be, only a few hours. They are not attended by iritis, and those liable to them have them over and over again.

There is an allied condition of inflammation of the eye-ball of much longer duration and greater severity which sometimes occurs to the gouty, and is curable by anti-arthritic remedies, which still falls short of iritis, and is never productive of adhesions. Of this, the case which I am about to narrate affords a good example. It also illustrates other points of much interest in reference to the results of inheritance of mixed tendencies to gout and rheumatism. Excepting by fruit-eating, it could not be held that the subject of it had done anything to augment or modify her inheritance. She had lived abstemiously, and had been for forty years an entire abstainer from alcoholic stimulants. Fruit, however, she had taken freely, and here perhaps was the chief error of her life. Neither gouty iritis nor attacks of hot-eye as a rule occur to young persons, and in the present instance the liability to attacks of ocular congestion did not commence till the age of fifty-five. In making this statement I put aside for the present the well-marked group of cases in which insidious iritis with affection of the vitreous occurs in young subjects who inherit.

Mrs. F——, 65, widow of Dr. F——. Although born in

Scotland, Mrs. F—— assures me that all her relations for several generations have suffered from gout. Her grandfather and her mother, both, for long went on crutches crippled by rheumatic gout. Four of her children have suffered severely, and two have had their eyes inflamed. She herself has had one acute attack in one great toe. She has passed uric acid in great quantities, although for forty years a total abstainer. She very often suffers from sudden sharp pains in her smaller joints. She has had neuralgia much, but never sciatica or lumbago. She has a well-marked arcus senilis. Her finger-nails are hard, bright, and polished (the nails of gouty persons). She considers that she has a weak heart; her lips are a little dusky. She never drinks tea, as it would, she thinks, make her heart uncomfortable and give her flatulence. She has been all her life exceedingly thirsty, needing to drink large quantities of water even soon after breakfast. She takes much lemonade, and formerly used lime-juice much. Although she has borne a large family and led an energetic life, she has always been dyspeptic, and often ailing. She has had several attacks of what has been called "gouty bronchitis."

The interesting point in Mrs. F——'s case is that she has become liable to attacks of arthritic inflammation of her eyes. The first was nine years ago, and she has had more than she can count since. The eyes become congested, "blood-red." Of late there has been severe pain "like a knife cutting into the eye." In her early attacks the pain was not great, and used to disappear when the congestion developed. Now the pain persists during the whole attack, and usually lasts a week. These attacks are apparently not iritis, for no adhesions have formed, nor are there any uveal deposits on the surface of the lens. Her pupil dilates well with atropine, but is not quite round. The structure of the iris is brilliantly distinct. There is no increase of tension. She sees well, but the eyes easily ache, and become hot if she reads long. She is hypermetropic as well as presbyopic, and some changes are commencing in the direction of cataract.

DISEASES OF THE NERVOUS SYSTEM.

No. XLIII.—*Liability to violent sick-headaches, from girlhood, with great coldness of feet—Early and profuse menstruation—Early marriage—Liability to neuralgia in right fifth nerve at the age of 25; at first paroxysmal, but afterwards constant during many years—Optic neuritis (double), with attacks of temporary blindness—Deafness in right ear—Recovery of health with persistent and most severe neuralgia, but without any evidences of aggressive cerebral disease.*

The following narrative contains the particulars of one of the most severe cases of neuralgia that I have ever known. The patient was under the care of my colleague, Mr. Tay.

The pain affected the distribution of the right fifth nerve, and when I saw the poor woman it had been continuous night and day for several years. She described it as a shooting, stabbing pain of excruciating severity, comparing it sometimes to a sewing machine at work in her face. Although continuous it had exacerbations, and these latter usually occurred every few minutes. She believed that she rarely slept more than a quarter of an hour at a time, but now and then, when utterly worn out with suffering, she has slept for two hours together.

The following are the notes which I took at the time (about ten years ago). During the night she asserts that she hears all the hours strike. She believes she usually feels the pain during sleep, and does not "quite lose herself." The pain has never, until quite recently, crossed the middle line in the least, but latterly she thinks it is extending to the

other side of the lip. She does not appear to know in the least the position of special nerve trunks, but says the pain is all over the side of the face, in the cheek-bone, forehead, &c. The slightest touch will bring it on, and she dreads any accidental contact with the skin, lips, or tongue. She used formerly to dread to eat or drink, but latterly she has found that, after bearing the first pain, she could continue to eat in tolerable comfort. Sometimes it has been fancied that the face, forehead, &c., were a little swollen. Her history of her affliction is the following :—

She is now aged 42. She was married in early life (aged 19), and had for some years much mental anxiety and trouble. She was not strong, but had no special illness. Menstruation was always too profuse and too frequent. At the age of 25 she was suddenly attacked by violent shoots of pain in the right side of the face, so severe that for a moment she thought she had been struck. These shoots continued to recur whenever the cheek was touched. She became liable to attacks of this neuralgia, which used to last a few days and then she would have several weeks intermission. In 1857 (aged 27) she for the first time became pregnant, and during her pregnancy, although not free from neuralgia, she was better than before. She suckled her child for thirteen months, but only in part. During lactation the neuralgia was bad, but not so bad as since. Her husband now failed in health, and after a long illness he died in Guy's Hospital in 1859. Soon after this occurrence she became much worse, suffered from attacks of violent vomiting, and found her eyesight gradually failing. It should be stated that she had all her life been liable to most violent attacks of sick-headache. It appears that the failure of sight was slow. She was liable to attacks of total blindness, which would last for a few minutes at a time ; these were attended by a sensation of loss of power generally. The attacks of blindness occurred sometimes four or five times a day, and the liability to them lasted several weeks. She was often when walking-out obliged to lean against a wall or get hold of a railing. Any little excitement brought on these attacks. She kept a stationer's shop, and often the mere fact of a customer coming in would cause her

such horrible pain in the eyes and forehead that she became blind, and had to hold on by the counter. After seven months she relinquished her shop and obtained a situation with a lady as companion; a month later, however, she had to relinquish the latter owing to the state of her sight.

After this she was for ten months under Mr. France's care with diagnosis "Amaurosis with cerebral symptoms," subsequently she was under Mr. McMurdo, Mr. Sydney Jones, and Mr. Croft at St. Thomas's. Her left eye had rapidly become so blind that she could only discern light with it, but the right, although very defective, still retained sight enough to be able to read large print. Muscæ and coruscations of light before the eyes were amongst her symptoms.

Her neuralgia for some years was subject each year to a three months' period of remission, during which she was almost wholly free. She does not think that the weather influenced it, but the remissions usually occurred in winter. When free from neuralgia she was liable to severe aching in all her limbs, in the muscles and bones. She thought these pains rheumatic. They were a good exchange from the neuralgia, for they occurred only in the night when warm in bed, whilst the former was continuous. She has had occasionally joint-aches, but has never been liable to any definite form of rheumatism. She does not inherit rheumatism. Her mother died young of consumption. Her father is living and aged, and suffers a little from rheumatism. Both parents were remarkably nervous. Her mother had nervous deafness, and used, under any excitement, to become quite deaf.

Amongst other symptoms which should be mentioned are *deafness in the right ear*. She believes that this came on at the time that her sight failed, and it was attended by constant noises, singing, ringing, &c., in the ear.

Liability to pins and needles in the extremities.—This symptom has occurred frequently in all the limbs, and has often been attended by cramp. For some years past her right arm has been especially affected by these sensations and by numbness. Often for weeks together it is never free.

Extreme coldness of feet.—All her life she has been liable to cold feet, but latterly more than usual. They are never

comfortably warm, but either—what is usual—as cold as ice or burning intensely.

She has not been nearly so liable to sick-headaches since her sight failed as formerly. She now takes beer and it does not disagree.

On the dorsum of the right foot she has a little round tumour the size of a pea, very probably a neuroma.

Present condition, October, 1871. The left eye diverges considerably. Both pupils are rather large, the right acts fairly, the left scarcely at all.

She is florid and looks in good health, but constantly carries her head stiffly, or a little on one side, to mitigate her pain.

Both optic discs are grey-white and dirty. The margins are notched, and the choroidal epithelium at their margins is much disturbed. The vessels are much reduced in size, both veins and arteries. The atrophic changes are more advanced in the left than in the right disc.

She allowed me to examine the face by pressure in various parts, stating that sometimes she could bear it, sometimes not at all. She had no special susceptibility over the principal nerve trunks.

Her appetite and digestion are fair, and her menstruation regular, and in spite of the persistence of her pain she manages to do some household work, moving always very deliberately. Weather and season exercise no influence on her pain.

Quinine has never done her any good. Opium will procure her sleep, but leaves her in great discomfort next day, so that she dreads it.

Her father had a few years ago an attack of neuralgia in the face.

She is better when out and moving about. Heat to the feet aggravates the pain immediately after its removal. She is very liable to flush after food.

It is interesting to speculate in this case as to the character and probable position of the organic disease upon which the neuralgia and other symptoms have depended. More than ten years have passed since the acute neuritis of the optic nerves

and the development of deafness on the neuralgic side might have seemed to indicate rapidly advancing mischief. Yet no advance has taken place. The cerebral symptoms are now almost in abeyance, and the neuralgia which persists has not passed into paralysis. That the cause is central may perhaps be inferred.

No. XLIV.—*Double optic Neuritis found in a case in which no Eye-symptoms had been complained of —Detailed description of a headache attending syphilitic gummata.*

Few cases could better illustrate the importance of the routine use of the ophthalmoscope * than that of Mr. W——. This gentleman, in the third year after a second attack of syphilis, was under my care for periosteal pains in his shins, but without any definite node. He had also a sore nose. I gave iodides, and his symptoms soon disappeared. This was in June and July. He left off the remedies, and in September took his holiday and did some shooting. In October he returned to me, saying that on two occasions during his month's holiday he had suffered from pain in the back of his head, with dulness of energy and great tendency to sleep. On each occasion a few days' use of the iodide had cleared his head and made him comfortable. He made no complaint whatever as to his sight, and he was engaged all day in reading and looking at figures. As a mere matter of rule, however, I examined his eyes, and with the result of finding both discs much swollen, the trunks of vessels concealed, and the choroidal rims blurred. I now tested his vision, found that he could see $\frac{20}{20}$ with R, and $\frac{20}{30}$ with L. He admitted when pressed that he had thought his sight not quite so good as formerly, and had on several occasions experienced a little dulness on rapidly rising from his seat.† He was, when I saw

* Dr. Hughlings Jackson was, I believe, the first to insist upon the importance of this practice, and especially to point out that a patient might be alleged to have perfect sight whilst yet the subject of optic neuritis.

† The temporary loss of sight on rising into the erect posture, as a symptom in cases of optic neuritis with good vision, is the subject of a note at page 184 of my last number of ARCHIVES. It is, I think, of some diagnostic importance.

him, cheerful, energetic, and voluble. He had quite relieved his headache by the iodides.

I thought it a good opportunity for recording the experience of a very intelligent patient as to the kind of headache from which he had suffered. He told me that the pain had been chiefly in his neck, but that it had extended to the back of the head. It had been very severe, but had never prevented sleep. It had been of a tensive kind, but attended also with pricking and sense of heat. In spite of it he had on several days continued his partridge-shooting, beer-drinking and smoking. The discharge of his gun did not make his head worse, and he added, "I shot well." He stated, however, that he did not enjoy himself in the least, was merely dragging himself about, and was exceedingly tired when he got home. On several days he had gone to bed at eight, being unable to keep awake, and had slept twelve hours. His headache was always ready for him when he awoke, though it never in the least kept him awake. He had no sickness, but had a poor appetite, and often felt giddy, especially on rising from his chair. He had never lost his ability to read, but on some days had been obliged to let his newspaper alone, because the reading of it oppressed his head, and as he said, "I could not remember one line when I was reading the next." The skull bones were often very tender to the touch, but no swelling had been ever found. On two occasions, as I have already stated, three days' use of his iodide mixture sufficed to restore him to comfort. It will be seen that the symptoms described were most probably due to the presence of meningeal gummata. The condition of the optic discs made this diagnosis almost a matter of certainty, and it was supported by the fact (twice observed) that the symptoms soon returned when he left off his medicine.

MISCELLANEOUS.

No. LXXIX.—*On Enlargement of the palatal glands.*

On the membranes covering the hard palate just anterior to its junction with the soft, there are a number of embedded glands. These are liable to hypertrophy, and become conspicuous as red points. At the same time the rest of the surface may become white, which makes the glands more conspicuous. They extend forwards, as large patches, right and left of the middle line, the latter being exempt. The form of each group is that of an obtuse cone, the base of the cone being the junction of the hard and soft palates. The soft palate remains florid and moist, and contrasts strongly with the white and comparatively dry areas which I am describing. The white condition extends outwards on the hard palate to the gums, but it never extends inwards so as to meet and join with the group on the opposite side. Very often a few isolated but very large glands are to be seen in advance of the apex of the conical group.

I am interested in describing these conditions, because they often, when discovered by the patient, or his medical attendant, give rise to needless anxiety. I have been consulted by several patients who believed that the glands were morbid growths, and of a dangerous nature. They are, I think, more common in the mouths of smokers than in others. They often cause a feeling of roughness appreciable to the fingers of the surgeon, or to the tongue of the patient.

No. LXXX.—*On the ease with which fœcal or urinary retention may be overlooked.*

Improbable as it may seem, it is yet quite true, that the sensations of the patient are often no trustworthy guide as

to the fulness or otherwise of the rectum or bladder. A patient will often declare "I have no difficulty whatever with my water," when yet his bladder is habitually full. In states of atony the ordinary sensations which attend distention are not produced. It is the same with the rectum and colon. Patients will assert that they have no constipation, "rather, indeed, the other way," when yet the rectum is blocked by a huge hardened mass, by the sides of which motions pass, which they consider adequate, and which may be fluid. Only those surgeons who are resolute in their efforts to secure objective symptoms, and make it a habit to avail themselves of all suitable excuses for digital examinations, can be aware how frequently, and often how wholly unexpectedly, such conditions are met with. Accumulations in the colon are probably quite as frequent.*

No. LXXXI.—*The effects of Fever in removing chronic ailments.*

The effect of a severe illness, attended by fever, in removing some chronic ailment, is not unfrequently observed. Nor are such illnesses by any means always observed to be in the end injurious to the general health. In a cotemporary biography of John Wesley, I find it recorded that two or three fevers from which at different times he had suffered, "seemed rather to have strengthened than impaired his constitution." He had also suffered from hydrocele, for which he had been several times tapped. "In June, 1775, being seized in the north of Ireland with a severe fever, it effectually cured him of this complaint."

No. LXXXII.—*Inheritance.*

We must, of course, draw a strong distinction between inheritance of a disease and of a tendency to a disease. In

* In the notes of a post-mortem on a patient under the late Mr. Hewson's care in the Lock Hospital, Dublin, I find it stated: "The condition of the large intestines in this female was very remarkable. The quantity of knotted feces which occupied the intestinal pouches was almost incredible, and this their condition the more claims attention when it is known that alvine evacuations had been regularly maintained during the whole time of the residence of this patient in the hospital."

the case of cancer it is probably, almost invariably, the inheritance only of proclivity; in the case of syphilis and smallpox it is probably the disease itself in the form of germinal matter which passes from parent to child. It may be so occasionally in the case of cancer, and then we must expect the disease to show itself very early in life.

No. LXXXIII.—*High and narrow palate in a tall person.*

Is the height of the palate usually in any ratio with the height of the individual? I have just seen a gentleman of six feet three inches and a half. He had a most remarkably high and narrow palate. Measured across from bicuspid to bicuspid it was little, if at all, more than an inch, whilst the arch rose an inch and half above a line level with the surfaces of the same teeth. He was a well-developed man of a family remarkable for tallness. I have seen many other examples of high palates in tall persons.

No. LXXXIV.—*Vomiting after Burns a serious symptom.*

A child was admitted into the London Hospital on the 1st of January, 1873, very severely burnt, and died in a few hours. It had vomited soon after coming in. The Nurse of the children's ward, a woman of long experience and of considerable powers of observation, remarked to me that she had only known two or three burnt children, who vomited soon afterwards, get well. She considered it an almost certain sign of a fatal issue.

No. LXXXV.—*Sneezing a sign of health.*

Do those who are seriously ill ever sneeze? In other words, may we take the occurrence of sneezing as proof of a degree of vigour and susceptibility on the part of the nervous system incompatible with severe disease? I certainly do not recollect to have ever seen any but fairly healthy persons sneeze. I put the question with especial reference to the widely spread popular superstition that sneezing is a sign of

health and good luck. It is possible that this may have had its origin in the fact that it is for the most part an act restricted to those in fair health. Tylor, who, in his "Primitive Culture," gives some most interesting facts as to the prevalence of this creed and as to certain customs connected with it, traces it in part to doctrines of Animism, but I cannot help thinking that the suggestion I have thrown out may also have some value.

No. LXXXVI.—*A symmetrical eruption of brown stains chiefly confined to the legs in a healthy lad —Persistence for several years, and then gradual disappearance.*

On March 18, 1890, Mr. Felix Stevens, of Stoke Newington, sent to me a boy of 13, who was the subject of an anomalous eruption. It had been slowly developing itself for two years, and he had been for some months under treatment by arsenic. This had been pushed until it disagreed, but had done no good. There was no history of family tendencies, with the exception of gout.

The eruption was confined to the lower extremities, with the exception of a single patch at the back of each ulna. It was accurately symmetrical. It consisted of deep brown stains of irregular shape, which were not thickened, nor were they either scaly or polished. They were not nummular, but somewhat irregular in shape, and varied in size from a sixpence to a crown piece. There was no itching. There were no spots on the trunk.

Two years later (January 26, 1892) I inquired of Dr. Stevens as to what had happened in this case, and I learned that the lad was in good health and almost free from his eruption. As the cure was not attributed to the remedies I need not specify them.

No. LXXXVII.—*An instance of the injurious influence of Arsenic in a Child.*

Another fragment of experience as to the effects of arsenic in young persons is the following: Mrs. H—— brought me

her daughter, a girl of 11, who, amongst other ailments, suffered from psoriasis. She had been, I was told, under the care of Dr. ——, naming a very excellent physician, who "had treated her wrongly and made her very ill with arsenic."

Mrs. H—— said that she had several times remonstrated that the medicine was making the child ill, and Dr. —— had always replied that she must go on, as it was the only remedy which could cure the skin disease. "But," I asked, "did it not cure the skin?" "Yes, it did once," was the reply, "but it was only when the child was looking very ill, thin, with careworn expression, and darkness around the eyes, and even then the spots came back directly the medicine was left off."

Amongst other symptoms of disagreement, in addition to these mentioned, the mother stated that the child became whilst under the influence of the mineral very nervous and hysterical. She never had sore eyes nor any fresh form of skin eruption.

Cases such as the above of course prove nothing against the use of arsenic where it agrees. They show only that in respect to it as well as other drugs we must study the idiosyncrasies of our individual patients.

No. LXXXVIII.—*On Mercury in the treatment of Jaundice in Dogs.*

On the treatment of chronic liver disease in dogs, Mr. Youatt writes: "The remedy should be some mercurial, with gentian and aloes, given twice in the day, and mercurial ointment well rubbed in once in the day. If this treatment is steadily pursued and a slight soreness induced in the mouth, the treatment will usually be successful." Mr. Blaine observes: "A moderate soreness of the mouth is to be encouraged and kept up. I have never succeeded in removing the complaint without it." In the disease referred to it is said that "the skin is usually tinged of a yellow hue, and the urine is almost invariably impregnated with bile."

In the present state of unsettled faith in drugs, we cannot afford to neglect items of evidence from any witness. It is

not so long since we were told, "as the result of conclusive experiments," that it is a mistake to believe that mercury has any action on the functions of the liver. So far am I from putting any faith in such conclusions, that I look forward with hope to a return of the time when calomel enjoyed the confidence of the public as well as that of the profession. I trust also that not only shall we again believe in the blue pill and black draught and the five-grain-dose of calomel, but that we shall have learned how to use long courses of minute doses. Recent experience in the employment of the latter against syphilis has convinced me that not only do they act specifically against that disease without in the least impairing the general health, but that they very often incidentally cure other maladies. Had we but faith enough to insist upon courses of mercury prolonged for a year or two at a time, I believe that very few need continue to suffer from habitual sick headaches.

No. LXXXIX.—*Note on the prevalence of true Ringworm in London sixty years ago.*

There is a prevalent idea that true Ringworm has much increased in England of late years. Whether it has done so or not is a matter of some interest in reference to our social habits. It has even been suggested—and I think with plausibility—that the disuse of pomades and hair-oils has favoured the easy implantation of the cryptogam. Although it has for long been very common in Paris and some districts in France, it is almost unknown in some other parts of the Continent. As a contribution to the history of the disease in London, the following notes have, I think, their value.

In 1827 Mr. Samuel Plumbe wrote a little essay on "Ringworm of the Scalp, Scalled-head, and other forms of Porrigo." He evidently knew common ringworm well. He speaks of its greater prevalence amongst the better classes, its intractability, and its disappearance as the patient advances in age. He admits that he failed in his treatment often, and says that his patients sometimes went over to Paris; adding, however, that he "never heard of one the better for the journey." His

name for ringworm was "porrigo furfurans." After describing his treatment, he writes :—

"In a few cases these measures have been followed by complete success; but the majority have, from the circumstances mentioned, been ultimately resigned in despair. It is a curious though very consoling fact, however, that a spontaneous disappearance of the disease occurs, in nineteen cases out of twenty, before the age of puberty arrives.

I fear that there are amongst us even now a few medical men of experience (and a much larger number of parents of experience) who would incline to acquiesce in Mr. Plumbe's candid record as regards results, and to hold that the only real cure for ringworm is to let the patient grow out of it. For myself I may avow my belief that the introduction of Goa powder, and its active principle chrysophanic acid, has supplied us with a new arm of the utmost efficiency. I seldom use anything else, and, with fair co-operation on the part of the nurse, I believe rarely fail.

No. XC.—*Mr. Plumbe's nomenclature, and his experience as to Favus.*

It is interesting to note that the "porrigo favosa" of Mr. Plumbe is not favus, but the contagious disease which, since Mr. Startin's time at Blackfriars, we have called "porrigo," or "contagious porrigo," in distinction from eczema. It was contagious to the nurses and to other children; it produced heaped-up bad-smelling crusts; was usually accompanied by lice; and usually caused enlargement of the cervical glands.

It may be doubted whether Plumbe had ever seen a case of true favus. I find nothing in his writings to prove that he knew the disease.

The "porrigo larvalis" of Plumbe was allied to his "favous porrigo," but affected the face rather than the scalp, and had more of eczematous tendencies. The term larvalis was earned when the eruption crust covered the features like a mask.

It is of great importance to note these discrepancies as to the names used, since, unless they are recognised, false im-

pressions may easily be formed as to the prevalence of certain types. Mr. Plumbe's experience as to true favus, or rather his entire lack of it, fits with that of the present time. By general consent true favus is in London, and indeed in England generally, a very rare disease. All statements to the contrary are based on errors in diagnosis. Mr. Malcolm Morris has recently made this point the subject of special investigation.

No. XCI.—*On differences in Temperature between Fingers on the same hand after division of the Ulnar Nerve.*

I believe that I have myself had some credit accorded me for an early record of observations on differences in the temperature of the fingers after nerve sections. The subjoined extract, which I take from an old Medical Journal and which was published soon after Sir Astley Cooper's death, shows that this subject had not only attracted his attention, but that he had endeavoured to make exact observations on it.

(*From Sir Astley Cooper's Note Books.*)

"Division of Cubital Nerve.

"I saw a girl, who had, twelve months before, divided the cubital nerve by a piece of glass, and just above the elbow. The glass was removed, the wound healed, but the girl had lost all sensation in the little finger, and partly in the finger next it. The finger was perfectly dead to sensation; it appeared purple, as did the back of the hand towards the little finger; it felt cold, and, upon the application of the thermometer, was found to be eight degrees below that of the middle finger of the same hand. Middle finger, 86°; little finger, 78°. She could move this finger. The nail also grew upon it, though not in proportion as upon the others."

I have much pleasure in reprinting this, not only as a measure of justice to the memory of a great surgeon, but as a contribution to the history of the clinical use of the thermometer. Hunter himself more than a century ago devised a modified instrument for biological research and figured it. It is not improbable that he used it at the bedside also, but I do not know of any proof that he did so.

No. XCII.—*Congenital defect of sight in three children of a family of four—Almost amounting to blindness in infancy, but with gradual improvement in childhood—Nyctalopia—Nystagmus—No other defect of the nervous system.*

A very interesting series of cases illustrating family defects was brought to me by Mr. V——, of Winchmore Hill. They were the three children of Mr. and Mrs. C—— of that place. E——, the eldest, aged 13, had very defective sight, and concerning her, as well as of all the others, it was asserted that she could see only in bright light, and not at all in the dusk. Her sight was believed to have been defective from birth, and she had never seen well enough to learn to read. At the age of four she had been examined by an able ophthalmic surgeon, Mr. Waren Tay, and a very unfavourable opinion had been expressed as to her probable future. In still earlier infancy she had been considered to be blind. Thus, although it was very difficult to estimate the exact amount of sight, either at the present or at former periods, the evidence made it very probable that she was slowly improving, and almost certain that she had gained since infancy. She was slightly myopic, but was not improved by glasses. Her vision was $\frac{6}{60}$. There was some nystagmus and alternating lateral deviation of the eyes. The ophthalmoscope showed thin choroids, discs rather pale and blurred, central arteries small, but veins of fair size. There was no trace of pigmentation of the retina.

The next child was a girl named M——, aged 11, who had perfect sight.

The third was a boy named J——, whose sight was defective, just like his elder sister's.

The fourth, an infant of eighteen months, named E——, appeared to be blind in like degree to that of her elder brother and sister, and, like them, supposed to be improving as age advanced.

In the boy J—— the ophthalmoscopic conditions were much the same as those described in his sister, but the changes in the disc were much less marked. He had no

myopia that could be corrected by glasses, and his vision, which was alike in the two eyes, was only $\frac{1}{60}$. His field was much narrowed. It is to be understood that the nystagmus which was present in both these cases, although slight, interfered considerably with the measurement of the field, the use of the ophthalmoscope, and the appreciation of vision.

We have, then, three children out of a family of four all affected in a similar manner. In all the eyes presented like conditions, and in none were the conditions apparently adequate to explain the defect. Great thinness of the choroid, but without the slightest trace of retinal pigmentation, and slight changes at the disc, indicative perhaps of imperfect development, or of intra-uterine neuritis, were all that could be found. There was no advanced condition of optic atrophy. None of the three children presented any other defect whatever. In none was there any degree of deafness. They were intelligent, good-tempered, and, making allowance for the want of sight, had got on well with their education. In all the teeth were well formed, and in none was the palate unduly high. The parents had been in no degree related before marriage, nor was there any known history of defective sight in any predecessor. It is of much interest, finally, to note that, reversing what is usually the case in retinitis pigmentosa, there appeared to have been progressive, though but slight, improvement in the defective function.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. CXXXVII.—*Croup and Diphtheria.*

QUESTIONS.

1. What was Dr. Alison's suggestion in explanation of the fact that in Scotland croup usually sets in during Saturday night?

2. Give other facts in support of the belief that exposure to damp air is often a cause of croup.

3. Is it true that croup usually begins in the night?

4. What was Dr. Cheyne's favourite remedy for croup?

5. At what stage of croup should the cure by the use of antimony be attempted?

6. Distinguish between emesis and nausea as to their beneficial effects in croup.

7. By what actions is it likely that antimony may prove beneficial in diphtheritic inflammations?

ANSWERS.

1. It is customary in Scotland to wash the house on Saturday afternoons, and from the damp thus produced the youngest children often get diphtheritic sore throat (croup).

2. Diphtheria is constantly observed to prevail in damp localities, and in the lowest lying parts of large towns. The banks of rivers and seaside places have long been reputed to suffer much from croup.

3. It is very usual for the more acute symptoms of croup to begin suddenly in the night. The child waking up with crowing respiration and difficult breathing. In most cases, however, there has been some degree of premonitory hoarseness and sore throat.

4. Antimony; which he used in large doses, and continued long. A good prescription is one grain dissolved in an ounce of boiling water, and the solution given in a dose from a tea- to a dessert-spoonful, according to the age of the child, every half-hour. The mixture is to be disused when sickness is produced, but resorted to again, after an interval, if necessary. The patient should also be put into a hot bath.

5. The earlier the stage, the more suitable is the case for the relief by antimony. Most cases in the first stage may be cut short by it. In the later stages ipecacuanha wine is a safer remedy.

6. It is possible to produce a prolonged condition of nausea without actual vomiting; and, on the other hand, it is possible to cause sudden vomiting without much long-preceding nausea. The one or the other effect may be obtained by modifications of dose. Long-continued nausea is attended by very considerable depression, much greater than that which results from the action of an emetic.

7. Antimony may be used either as a nauseant or as an emetic, and is useful in both directions. During the state of nausea there is much less tendency to fibrous effusions and an increase of fluid secretions. Thus the membranes may be loosened, and the subsequent occurring of vomiting may favour their ejection. It is well known that cases of diphtheria with dry surfaces are the most dangerous, and thus the action of antimony in favouring transudation of fluid may be very valuable.

No. CXXXVIII.—*Uses of Antimony.*

QUESTIONS.

1. What is the proper dose of tartarised antimony when given to an adult to counteract an acute inflammation?
2. Are the effects of antimony tolerably uniform?
3. What are its most marked effects?
4. Is it a safe remedy for children and delicate persons?
5. Should it be given before or after food?
6. Has antimony any definite effects in cases in which it does not produce nausea.

7. What is the chief difference in action between antimony and ipecacuanha?

8. Is it a reasonable statement that ipecacuanha "is somewhat depressing to the system, but less so than tartar emetic"?

ANSWERS.

1. A good rule for the use of antimony is to prescribe always one-sixteenth of a grain, and to give the dose every hour or less frequently according to the effect desired.

2. They are very uniform. You may rely with confidence upon the sequence of certain results.

3. The constant result when the remedy is pushed is a feeling of nausea and slight faintness. The face becomes pale, and there is a tendency to perspire. Vomiting and diarrhœa, with entire temporary failure of muscular strength, may follow.

4. It is quite safe if given cautiously in small doses with the direction to stop its use as soon as nausea is felt.

5. It should always be given on an empty stomach unless it is definitely wished to avoid its nauseant effect, and possibly to render it useless.

6. It is very difficult to feel certain on this point, but probably it does favour the equable distribution of blood, and the secretory functions of all glands.

7. Ipecacuanha may be called vegetable antimony, for the effects of the two are very similar. Ipecacuanha is, however, more prone to cause vomiting without the intervening stage of nausea, and it is impossible to produce even with large doses the profound depression which results from antimony.

8. Such a statement is for the most part meaningless since everything depends on the dose. Tartar emetic may be given in such doses that it is a tonic and not a depressant at all. If, however, the two drugs be pushed to nausea, then it is true that the nausea of ipecacuanha will be attended by less influence on the vascular system and muscles than that of antimony.

No. CXXXIX.—*On Prescribing Antimony.*

QUESTIONS.

1. In what doses may tartarised antimony be given for chronic disease where it is not desired to nauseate?

2. How long may it be so used, and what are its effects?

3. For what diseases would you so prescribe it?

4. What conjecture may be offered in explanation of the influence of antimony in improving the appetite?

5. What are relations of antimony and opium to each other? Under what conditions of disease would you combine them?

ANSWERS.

1. A sixteenth of a grain given three times a day will rarely occasion nausea, and may be continued for many months with the usual effect of improving the appetite and health. These doses often appear to much diminish irritability and congestion in the skin and the mucous membranes. Patients acquire tolerance of antimony, and the dose may in some cases be increased to one-eighth or a quarter of a grain.

2. It may be used for many weeks or months, or, indeed, quite indefinitely.

3. It appears to have very good effects in chronic congestion of the skin and mucous membranes. It is especially adapted for those in whom there is a defect of secretion. Thus chronic eczema or seborrhœa, are often very much benefited by it. It also abates irritability in all pruriginous affections. In some cases of lichenplanus it appears to have an almost specific action.

4. It may act by diminishing local congestions and general febrile irritability. As it favours glandular action it may increase the secretion of the gastric juice.

5. Opium tends to diminish the depressant effects of antimony, and to some extent it possibly prevents its action in general. The combination of the two, however, in states of irritability attended with local congestions is often admirable in its effects. When antimony is given to aged persons, especially to those who are weak, it may generally be combined with a little opium.

No. CXL.—*On Prescribing Antimony.*

QUESTIONS.

1. Why should tartarised antimony be given on an empty stomach, or at any rate not immediately after food?

2. With what drugs is antimony incompatible?

3. What plan of diet should be enjoined during the use of antimony?

4. What is the meaning of the old word antiphlogistic?

5. In what respect is tartarised antimony superior to all other forms of the metal?

6. How is it best prescribed?

7. What is the strength per drachm of antimonial wine?

ANSWERS.

1. Antimony forms an insoluble compound with astringents and with alkalies and their carbonates. It is, therefore, very possible that it may be neutralised by various articles of food. The direction to take the dose after meals may easily be equivalent to not taking it at all.

2. Bark, rhubarb, tannic, and gallic acids must not be combined with antimony. Thus a favourite prescription of a late distinguished ophthalmic surgeon of tartarised antimony in tincture of bark was probably equivalent to giving bark alone.

3. If antimony be used with the hope of checking an acute inflammation, all stimulants and tonics should be avoided, and a distinctly low diet should be enjoined. It is quite possible, however, that in chronic cases antimony may exercise some good influence when taken in conjunction with ordinary diet.

4. The term antiphlogistic was formerly in common use for any method of treatment which tended to restrain inflammatory action and to reduce local congestions. A great number of remedies acting in different ways come into this class, but the most typical and efficient of them all is probably antimony.

5. Tartarised antimony is preferable to other preparations on account of its easy solubility.

6. It is best prescribed dissolved in water (boiling at the time), and with the addition of a little mucilage to secure suspension. No other drug should be combined with it.

7. A teaspoonful contains a quarter of a grain. Antimony is only imperfectly soluble in wine, and its solution in water only is more certain to be uniform.

No. CXLI.—*Elephantiasis.*

QUESTIONS.

1. What clinical varieties in elephantiasis may we recognise?

2. Is there any definite distinctions to be made between elephantiasis as seen in temperate climates, and when endemic in the tropics?

3. What influences probably explain its endemic prevalence in hot countries?

4. What is known as to its probable association with the Filaria sanguinis?

ANSWERS.

1. A great number of clinical groups of elephantiasis might be constructed in relation to different states of the patient's health, the part affected, and the exciting cause. Attacks of erysipelas occurring in dependent parts—the leg, for instance—are its common exciting causes, and the recurrence of repeated but milder outbreaks of the same malady is usually the cause of its increase. We may speak of symmetrical and of unilateral elephantiasis, of smooth elephantiasis and tuberculated form, of sporadic and endemic elephantiasis, but it is to be understood that fundamental to all these is the liability to recurrent erysipelas with its attendant solid œdema.

2. Elephantiasis is common in the tropics, especially in some regions, whilst it is rare in England. It is often symmetrical as seen in the tropics, and it is almost invariably restricted to one limb, as witnessed in England. We may infer, therefore, that constitutional influences take a much greater share in its production in countries where it is endemic than is the case in temperate climates. These influences are great heat, a moist atmosphere, and the presence

PLATE LXVI.

SOLID ŒDEMA OF THE EYELIDS.

This plate shows the portraits of two women who were the subjects of that form of solid œdema which not unfrequently occurs as a result of repeated attacks of an erysipelatous swelling of the face. The disease may occur at any age, but is more common in adults than in young persons, and produces, as a rule, more conspicuous deformity in women than in men. I have published on different occasions a considerable number of examples of this malady. The usual history is that the patient has been liable for years to recurring attacks of erysipelas, transitory in duration and limited to the face, but attended with very considerable œdema.

The final condition is one allied to Elephantiasis. The disease is wholly local.

West, Newman, lith

of malaria. Elephantiasis is, however, essentially the same disease in all countries, and in the sporadic cases seen in England the conditions are often as highly developed as in the worst tropical cases. There are, therefore, no definite distinctions to be traced.

3. All influences which tend to degrade the vigour of nutrition may increase the tendency to elephantiasis and favour its development when once begun. Thus heat, moisture, and malaria are in turn and in combination all influential.

4. Although in tropical patients the filaria is commonly found in the blood of elephantiasis patients, yet as it is absent in cases seen in temperate climates which are exactly the same in character, it is impossible to assign to it the rank of a true cause.

No. CXLII.—*Fatality of Exanthemata in relation to Age.*

QUESTIONS.

Miss Yonge, in one of her interesting novels, has depicted the misfortunes of a high-born curate who, during his early life, had been sedulously guarded against all risk of contracting children's diseases. Entering zealously upon his parochial duties he was laid up in turn with whooping cough, measles, chicken pox, and scarlet fever. The lesson which the reader is intended to draw is (in conformity with a wide-spread belief) that it is better to get these maladies over in childhood. How far is such a belief justified by facts?

1. Is the fatality of scarlet fever greater in childhood or in adult life?

2. Does the mortality from small-pox differ at different ages?

3. Are all forms of fever more fatal in infancy and early childhood?

4. How are the facts in reference to diphtheritic inflammations (diphtheria)?

ANSWERS.

1. The fatality of scarlet fever is far greater in early childhood than it is in adults. Thus whilst under the age of two years

it may average 30 per cent., and between the ages four and five as much as 12 per cent., after the age of 15 it scarcely reaches 5 per cent.*

2. The mortality of small-pox is greater during the first two years of life, after that it diminishes until adolescence, when it again increases.

3. The fatality of diphtheria is most definitely ruled by age. The younger the patient the more severe the disease, the more difficult the treatment, and the greater the risk of death.

4. It is a very remarkable fact that typhus fever is scarcely ever fatal in infants and young children, whilst it is very dangerous in adults past middle life.

No. CXLIII.—*The Tongue.*

QUESTIONS.

1. How many kinds of papillæ are there on the tongue?
2. Of what does the "fur" on the tongue consist?
3. In what conditions is it common for fur to accumulate?
4. How do you explain unilateral fur?
5. What is meant by an "indented tongue"?
6. If one lateral half of the tongue be wasted and flabby, what lesion would you suspect?
7. How would you test the state of the tongue as regards paralysis of the hypoglossal nerve?
8. What is the clinical significance of an indented tongue?

ANSWERS.

1. Three—filiform, over whole surface; fungiform, at sides and tip; and circum vallati, or calyciform, eight or ten in number at base. All these papillæ are compound, *i.e.*, covered with simple ones, and in addition to them are numerous minute simple ones more or less buried in the epithelium.

2. Accumulation of epithelial scales on the papillæ.

3. Whenever the tongue is not used in the mastication of solids fur may be expected to collect. Thus it is a symptom

* These figures are taken from the statistics of The Metropolitan Asylums for 1890, page 11, and are based upon nearly 37,000 cases.

of want of appetite in general. It is, however, liable to much modification in connection with personal peculiarities.

4. Unilateral fur implies that its subject masticates chiefly or solely on one side of his mouth. The side of the tongue on which he eats will clean and the other remain coated. Thus it may imply want of teeth, or toothache, or one-sided paralysis.

5. A tongue, which, being soft and somewhat œdematous, has received at its edges the marks of the teeth against which it has pressed.

6. Paralysis of the hypoglossal nerve. The wasting is of substance of the lingualis muscle.

7. Take the two sides of the tongue between the finger and thumb of each hand, and then direct the patient to forcibly thrust the tongue out of the mouth. The non-paralysed side will at once become hard and the other remain soft and flabby.

8. It is often little more than a personal peculiarity. It may be a relic of a former salivation. It may imply general want of tone and tendency to œdematous state of the solids.

No. CXLIV.—*The Cremaster Reflex, &c.*

QUESTIONS.

1. What is meant by the cremaster-reflex?
2. At what age is it most vigorous?
3. Under what conditions is it absent or diminished?
4. How is it produced?
5. How is the cremaster innervated?
6. At what part of the back does the spinal cord end?
7. How is the sphincter ani supplied by nerves?

ANSWERS.

1. On sharply tickling or scratching the inner part of the thigh the testicle is drawn up. This is called exciting the cremaster-reflex.

2. It is most vigorous in boys or in early adolescence.

3. It is absent in aged persons and in states of sexual debility and neurasthenia, also in tabetic affections.

4. It is due to the anatomical fact that this region of skin is supplied by the same nerve as that which gives motor power to the cremaster.

5. The cremaster muscle is supplied by the genital branch of genito-crural, which is derived from the second lumbar. The crural filaments of the same are distributed to the skin of the upper and front part of the thigh.

6. The spinal cord ends and the cauda equina begins at the first lumbar vertebra.

If the genito-crural tract of skin on front of thigh has escaped sensory paralysis, as proved by the possibility of exciting the cremaster, then we may be certain that the disease or injury is below the level of origin of the second lumbar nerve. This applies, however, only to recent injuries and to disorganising disease, for the reflex functions of the cord may be recovered after a time below a well-localised lesion, and may even be in excess.

7. The external sphincter ani is supplied from the lower part of the sacral plexus by filaments derived from the pudic thigh, the inferior hæmorrhoidal.

It is probable, however, that it is the internal sphincter which is the chief means of the retention of feces under ordinary circumstances, and that the external sphincter is employed only in volitional contract. The internal sphincter receives its supply chiefly from the vaso-motor, and may be efficient when the other is lost.

No. CXLV.—*The Urine, &c.*

QUESTIONS.

1. What is the normal rate of respiration?

2. What quantity of urine should a man pass in twenty-four hours?

3. With what other function is the quantity of urine usually in relation?

4. What is the state of the skin in diabetes?

5. Is the urine more freely secreted during sleep or when awake?

ANSWERS.

1. Fourteen to eighteen per minute.

2. In summer thirty ounces, and in winter forty ounces.

3. With the activity of the skin. If there be much perspiration there will be but little urine.

4. Almost invariably dry.

5. It is much diminished during sound sleep, and increased when awake, as any one may observe who will relieve his bladder as soon as he wakes after a six hours' sleep, and then remain in bed, awake, another hour.

No. CXLVI.—*Hemicrania.*

QUESTIONS.

1. What are the more common symptoms of hemicrania?
2. Is the pain in the skin?
3. Does it always prevent sleep?
4. Is the pain intermittent?
5. Does any affection of muscles ever attend hemicrania?
6. Are there any special disturbances of function?
7. What is the usual effect of stimulants and food?
8. Does the pain often change its place?

ANSWERS.

1. A severe, persistent, tensive pain or ache in one frontal region. The pain is aggravated by motion of the head, and compels the patient to hold his head still with the utmost care. Sometimes "shoots of pain" occur, but this is not a common or prominent feature. There is tenderness on firm pressure over the painful parts, and especially upon and under the margin of the orbit. Although there is a degree of tenderness, yet the painful part bears firm pressure, and is sometimes even relieved by it.

2. The tenderness is not in the skin, but deeper, in the bone or periosteum. There is often slight swelling of the eyelids and of the parts beneath the eyebrow.

3. The pain does not usually prevent sleep.

4. The pain often recurs every day, and comes on at the

same time in each day. Very often it comes as soon as the patient leaves his bedroom.

5. There is usually some lachrymation, which is aggravated by exposure to artificial light or by attempts to read. The attempt to use the accommodative function is always painful —hence the difficulty in reading.

6. In very bad cases there may be some defect of power in the muscles of the side affected. Partial ptosis or spasmodic contraction of the orbicularis or of the muscles of cheek.

7. Food and stimulants sometimes produce temporary relief.

8. The pain, although fixed usually to one side, may now and then change about. Not infrequently the occiput is affected, or the mastoid region, and sometimes the opposite forehead.

No. CXLVII.—*Use of Setons in Eye Diseases.*

QUESTIONS.

1. What are the indications for the use of setons in diseases of the eye?
2. Where should the seton be put?
3. What is the special risk?
4. What material should be used for the seton?
5. How long should the seton be left in?

ANSWERS.

1. They are to be used in cases of corneal ulceration which are intractable under other methods, and more especially if they are attended by pain. In such cases they are of the utmost value.

2. In the skin of the temple, well back amongst the hair so that the scar left may not be seen.

3. There is risk of wounding a branch of the temporal artery with the seton needle. The bleeding is sometimes very troublesome.

4. Two strands of thick silk are sufficient, or if the thickest be not at hand four of a medium size may be used.

5. A month or six weeks—that is, until the eye is quite well.

No. CXLVIII.—*Tumour of Face and Neck.*

QUESTION.

From the appearance of the swelling represented in the woodcut, taken in connection with the age of the subject, what would be the conjectural diagnosis as to the nature of the disease?

ANSWER.

The patient is a child; the swelling bulges largely on the cheek, and less so in the posterior triangle of the neck. Neither its form nor its positions are those which are usual in strumous disease of the glands. Nor does the tumour on the face keep to the position of the parotid gland. It is, on the other hand, in a position in which congenital nævoid and cystic tumours are not infrequent. The tumour was probably of this class. These growths, although present at birth, are liable to increase in the first few years of life, and are also prone to attacks of inflammation, during which they swell up to a large size. These inflammations may be attended with sharp constitutional disturbance, and may even end fatally; more usually, however, they subside after a few weeks, and the tumour then shrivels, leaving the skin flabby

and loose. [Such was the course of the disease in the case of the patient whose portrait is here shown.]

No. CXLIX.—*Foreign bodies in the Ear.*

"A Surgeon Censured.

"At Innspruck in Tyrol a young man got a caroub-bean shoved into his ear by a mischievous boy. The bean swelled and gave the patient some pain, which caused him to visit a doctor for the removal of the foreign body. The surgeon attempted the removal of the bean by means of a curved probe, and during the process of extraction he somehow broke the drum of the ear. Acute inflammation of the middle ear and tympanum was set up, and the patient died in excruciating agony seventeen days after the accident. The surgeon was censured for his want of skill by the Faculty of Medicine of Innspruck, and required to submit to an examination in surgery before he be allowed to again practise."

QUESTIONS.

1. Was the censure of the surgeon under the circumstances described in the above paragraph deserved?

2. What answer ought he to be expected to give, at his second examination, as to the treatment appropriate for such a case? *

ANSWERS.

1. A bean is, on account of its liability to swell with moisture, one of the most difficult of all substances to extract with safety from the ear. Many patients have died from the efforts of the surgeon in such cases. There is in the museum of the London Hospital the temporal bone of a child who died precisely under the circumstances described in the extract. The censure and the sentence were, perhaps, too severe; yet should their publication have the effect of deterring others from the use of scoops, bent probes, &c., for the removal of foreign bodies from the ear, they are, perhaps, not to be regretted.

2. He should be required to say that he would in future never use either probes or scoops, that he would always in the first instance employ an efficient ear-syringe, if necessary placing his patient on a high table with the ear looking

* I hope none of my readers will suspect me of having invented this case. It is true that I wrote very strongly years ago in reprobation of the practice described. The case, is however, copied verbatim from a medical journal.

directly downwards; that his next measure, if the syringe failed, would be the employment of a loop of soft silver wire, to be placed under the foreign body. If—as in the case of an already swollen bean is very possible—both syringing and the wire loop should fail to extract it, it would be safer to desist from further efforts, and trust the substance may soften and come away piecemeal.*

No. CL.—*Detachment of Lower Epiphysis of Femur.*

The appended woodcut shows a clean and complete detachment of the lower epiphysis of the femur. The muscles of the leg have been dissected, in order to show the relation of those of the calf to the epiphysis itself. The lower half of the femur has been cleaved, in order better to exhibit the form of its epiphysal end. The specimen was obtained by a primary

* In 1863 I described and figured the loop of wire to be used for this manipulation. Since then I have employed it repeatedly, and it has never failed in my hands. I have not, however, had to do with swollen beans, and am quite ready to admit that they may occasionally present insuperable obstacles to all safe methods of abstraction. I invariably use the loop of wire if the use of the syringe is not speedily effectual. I have used the loop also for the extraction of foreign bodies from the trachea.

amputation in the case of a boy, aged 14, under my care some years ago in the London Hospital.

QUESTIONS.

1. Up to what age is detachment of this epiphysis possible?
2. Is it usually attended by complete dislocation of the epiphysis from the shaft?
3. What is the usual displacement of the epiphysis when the dislocation is complete?
4. How should such displacement be remedied?
5. Do any specimens exist in our museums illustrating union after this accident?

ANSWERS.

1. The lower epiphysis of the femur may be detached at any age under 20; but the accident usually occurs between 8 and 18.

2. Fortunately, the complete displacement of the shaft from the epiphysis is rare, even in cases where the separation is quite complete. The surfaces separated are large, and that of the shaft does not usually leave the whole of that of the epiphysis.

3. If the epiphysis has been completely disengaged from the shaft, the tendency will be for it to be displaced by the gastrocnemius into the position of full flexion at the knee: this is the position which is shown in the woodcut. Much must, however, be allowed for the direction in which the violence has been applied.

4. It may be quite impossible to alter the position of the epiphysis; the best chance of doing so will be by first effecting reduction, with the knee bent at right angles, and then partially straightening the limb. The treatment of such cases, is however, extremely difficult and unsatisfactory.

5. Exceedingly few specimens in illustration of this accident, at any stage, are in existence. There is one, illustrating union, in the Museum of the Royal College of Surgeons, from Mr. Liston's collection. It shows displacement of the epiphysis forwards, relatively to the shaft—that is, the reverse of what has just been described.

PLATE LXV.

MOLLUSCUM FIBROSUM.

This plate, copied from a photograph, shows the present condition of the man Gray, whose face was depicted in Plate LXIV., given in the last number of Archives. His portrait is also published in the New Sydenham Society's Atlas. These portraits prove that the disease, Molluscum fibrosum, tends to increase as age advances. I possess a considerable number of photographs of molluscum fibrosum patients which have been sent me by friends from all parts of the world. All the patients in whom the disease is severe are in adult life, but, with the exception of these portraits of Gray, I do not know of any which show the condition in the same patient at different periods of life. It is probable that in most, if not in all cases, the tumours continue to increase in size, and multiply in numbers, from adolescence up to middle age. If I were to speak from my own experience and from the evidence afforded by my collection of photographs, I should incline to say that these severe forms of molluscum fibrosum, which go on increasing through a patient's life, occur exclusively in males. I have never seen a severe case in a woman, although solitary tumours are not infrequent. Gray's age is now about 50, and the tendency began to show itself when he was a boy. The first portrait was taken when he was 27.

West, Newman, lith.

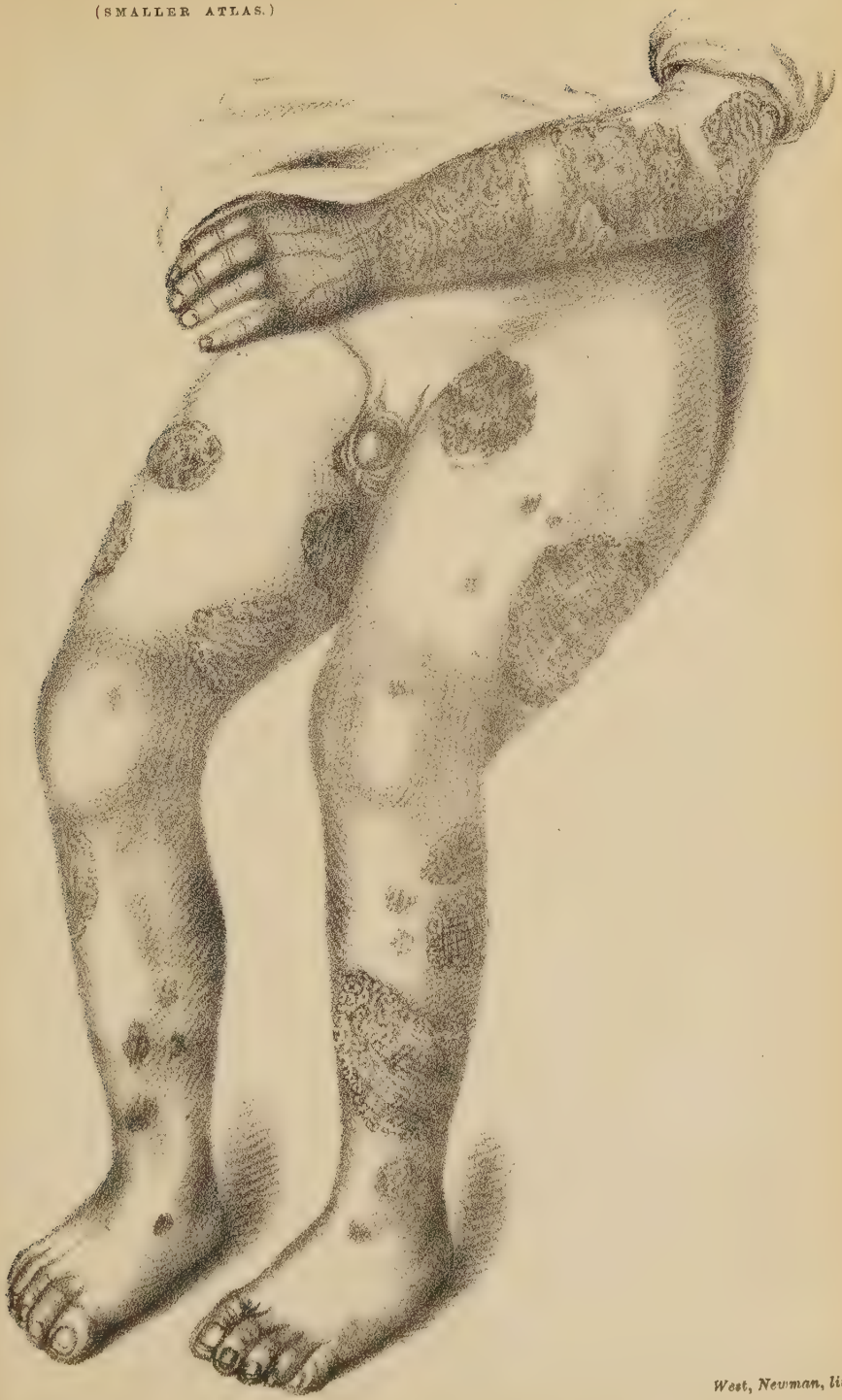
PLATES LXVII. & LXVIII.

LUPUS VULGARIS (MULTIPLE).

These two plates represent the lower extremities and fore-arm of the same patient, with an interval of four years. He was a boy of 4 when the portrait, of which Plate LXVII. is a copy, was taken, and was nearly 9 when the other was done. They are to be considered as little more than maps, designed to illustrate the location and size of the diseased patches. It will be observed, on comparing the two, that everywhere the patches have increased in dimensions, and that in many places two or more have coalesced. On the right leg in particular the later sketch shows patches of considerable size, where in the earlier one there were but small spots. The foreskin, which in the earlier portraits is seen involved in disease, had been removed by circumcision before the second one, and the parts were soundly healed.

The disease represented in these figures was Lupus vulgaris, occurring in multiple development. Its particular features will be better appreciated by reference to the coloured portraits which form the subjects of Plates LXXVI. and LXXVII., and which represent the same patient. The case, which has already been referred to in my Harveian Lectures on Lupus, is that of a boy named L——; his disease, which commenced by a parent patch on one arm, developed itself very rapidly as a generalized eruption of a lichenoid and pustular character, which assumed some of the features of rupia. It was not identified as lupus until it had been present for a year or more, but it ultimately assumed all the characteristic features of the non-ulcerating form of that disease. The child, who is still living, is still the subject of immense patches of lupus. The disease has been throughout too extensive to permit of the efficient employment of local treatment. No advantage was obtained from the use of injections of Koch's fluid. It is of importance to notice that, although in this case the lupus occurs as a generalized eruption, the patches being very abundant and on both sides, yet they are not actually symmetrical; in this feature lupus vulgaris, however plentiful the patches may be, always differs from the ordinary type of lupus erythematosus. The latter is usually, though not invariably, arranged with the most definite symmetry; the former is never so.

West, Newman, lith.



West, Newman, lith.

PLATES LXXVI. & LXXVII.

LUPUS VULGARIS (MULTIPLE).

PLATES LXXVI. and LXXVII., which belong to the same case as Plates LXVII. and LXVIII., already described, represent the face of the little boy with an interval of four years, and show well the changes in character of the disease as well as its advance at the borders of all the patches. In the earlier portrait doubts might be suggested as to the diagnosis of Lupus; respecting the later one none whatever can be felt. The portraits are therefore of great value as illustrating the early stage of this disease, and I am not aware that any others of a similar character have as yet been published. The remarks made in the description of the previous plates, in reference to the absence of accurate bi-lateral symmetry in the location of lupus vulgaris, are well illustrated in these portraits.

It may be well to draw attention to a very important fact which these four portraits illustrate, that lupus vulgaris, when once established, does not tend to produce any new patches; its multiplicity is almost invariably attained (if at all) in its very earliest stage. After that, although the individual patches tend slowly to increase in size, and may indeed extend at their margins indefinitely, no new ones are produced.

West, Newman, chromo

West, Newman, chromo

PLATE CII.

DUHRING'S NEOPLASM.

(COPIED.)

THIS portrait is copied from one which was published by Dr. Duhring, of Philadelphia, in 1880, and illustrates the disease to which the name of "Duhring's neoplasm" has since been accorded. Dr. Duhring's paper is a very able one, and deals very fully with the facts which seem to show that the disease illustrated stands as a sort of connecting link between inflammation and new growths. It has since been claimed by other writers as an example of granuloma fungoides, and, as such, has been associated with cases to which it bears no very close similarity.

The patient was a woman past middle age, who died in May, 1879. The details of the autopsy are recorded in "Archives of Dermatology," January, 1880. Briefly, it may be stated that she had suffered from a skin disease during more than two years, which had been characterised by growths similar to those shown in the portrait, which would fungate and ulcerate, and were attended by much fœtid discharge. A tumour on her forehead is said to have resembled a huge roasted tomato. A very remarkable feature in the case was that some of the tumours would, from time to time, shrivel and disappear. There was little or no implication of the lymphatic glands, but towards the end of the case enlargement of the parotid and submaxillary glands took place. On various occasions some of the tumours were excised and their histology carefully investigated. The boundaries of the growths were very ill-defined, and of those which had undergone spontaneous removal it was in some cases impossible to discover any trace whatever. It is stated that iodide of potassium always produced alarming exasperations, but it was not thought that the iodide was responsible for the beginning of the disease. At the autopsy no tumours were found in the viscera, with the exception of a number of almond-shaped tumours, half an inch in thickness, under the mucous membrane of the bladder. Even after the most detailed microscopic examination there remained much difference of opinion as to whether the growths should be classed as sarcomata or not. Dr. Duhring himself thought that they ought not, and concluded his narrative with the very suitable caution, "Better let it be unnamed and unclassified than be placed and become fixed wrongly."

H. Praeger, M.D.